

SHOCKED, EXHAUSTED, AND INJURED: THE CANADIAN MILITARY AND
VETERAN'S EXPERIENCE OF TRAUMA FROM 1914 TO 2014

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By:
Adam Montgomery

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ABSTRACT

The Canadian military and veterans have a long history of dealing with psychological trauma caused by war and peacekeeping. Over the past century views about trauma among physicians, military leaders, society, and veterans' themselves have been shaped by medical theories, predominant views about the ideal soldier and man, and the nation's role in international affairs. Since the First World War, major conflicts and peacekeeping operations have been responsible for distinct shifts in how trauma is conceptualized, named, and experienced by Canadian soldiers and the public. Canadian historians have examined this subject by looking at particular wars, most notably the First World War, but no attempt has been made to provide a monograph-length study of military trauma over the past century. This thesis utilizes several lenses – medical, social, and cultural – to explore how conceptions of trauma changed from 1914 to 2014, how such changes affected veterans in their civilian life, and the interactions between medical and popular knowledge, military culture, and veterans' lived experiences. With a particular emphasis on the latter, it uses oral interviews with veterans of the post-Cold War, government reports, medical literature, and national newspapers to track shifts in consciousness about trauma and its social and medical treatment. It argues that despite numerous changes in medical thought and popular understandings of trauma, stigmas about psychological illness persisted, and that masculine ideals inherent in 1914 were still present, albeit in an altered form, one-hundred years later. It also argues that the Canadian veteran's experience demonstrates that from 1914 to 2014, trauma consistently oscillated between being a medical entity and a metaphorical representation of war, peacekeeping, veterans' socio-economic struggles, and national identity. This thesis takes advantage of a historically unique openness in the Canadian military since the year 2000 to contribute to a growing literature about trauma in Canadian military history and society.

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List of Abbreviations

APA: American Psychiatric Association

ARTAL: Adjustment Reaction to Adult Life

BOI: Croatia Board of Inquiry

CAF: Canadian Armed Forces

CAR: Canadian Airborne Regiment

CBC: Canadian Broadcasting Corporation

CDS: Chief of the Defence Staff

CEF: Canadian Expeditionary Force

CF: Canadian Forces (Used interchangeably with CAF and “Forces”)

CFB: Canadian Forces Base

CISD: Critical Incident Stress Debriefing

CJP: Canadian Journal of Psychiatry

CMHA: Canadian Mental Health Association

CNCMH: Canadian National Committee for Mental Hygiene

CPA: Canadian Psychiatric Association

CSS: Combat Service Support

DND: Department of National Defence

DPNH: Department of Pensions and National Health

DSCR: Department of Soldiers’ Civil Reestablishment

DSM: Diagnostic and Statistical Manual of Mental Disorders

DVA: Department of Veterans’ Affairs

GAP: Group for the Advancement of Psychiatry

GSR: Gross Stress Reaction

GWS: Gulf War Syndrome

IPSC: Integrated Personnel Support Centre

JPSU: Joint Personnel Support Unit

MHC: Military Hospitals Commission

MHCHC: Military Hospitals and Convalescent Homes Commission

MND: Minister of National Defence

MOD: (British) Ministry of Defence

MPCC: Military Police Complaints Commission

NATO: North Atlantic Treaty Organization

NDHQ: National Defence Headquarters

NIMH: (United States) National Institute for Mental Health

NVC: New Veterans Charter

OSI: Operational Stress Injury

OSISS: Operational Stress Injury Social Support

OTSSC: Operational Trauma and Stress Support Centre

PPCLI: Princess Patricia's Canadian Light Infantry (Battalion numbers placed before, e.g. 2PPCLI)

PSC: Peer Support Coordinator

PTSD: Post-Traumatic Stress Disorder

RCAMC: Royal Canadian Army Medical Corps

RDC: Research Diagnostic Criteria

SCONDA: Standing Committee on National Defence and Veterans' Affairs

SISIP: Service Income Security Insurance Plan

TLD: Third Location Decompression

UN: United Nations

UNAMIR: United Nations Assistance Mission for Rwanda

UNEF: United Nations Emergency Force

UNPROFOR: United Nations Protection Force

VA: (United States) Veterans Administration

VAC: Veterans Affairs Canada

VVAW: Vietnam Veterans Against the War

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INTRODUCTION: TRAUMA, CULTURE, AND HISTORY

Barry Westholm joined the Canadian Armed Forces (CAF) in 1982 in London, Ontario. Unlike numerous comrades, Westholm was not a “base brat” from a military family. Instead he deemed himself an “accidental soldier.”¹ As a youth that got into “a fair bit of trouble,” the military helped him occupy his idle hands and satiate his need for adventure.² He trained first at Canadian Forces Base (CFB) Cornwallis in Nova Scotia, and then CFB Borden in Ontario, ultimately finishing his apprenticeship training as a vehicle technician at CFB North Bay in Ontario in 1985.³ After completing his training, Westholm was stationed at Canadian Forces Europe in Lahr, West Germany, in 1987, where he remained for three years, giving him the opportunity to witness firsthand the fall of the Berlin Wall in November 1989.

Although the Cold War was over by 1991, the 1990s brought no rest for the CAF, which saw its personnel committed to a number of peacekeeping missions around the world. In 1992 Westholm went on his first United Nations (UN) mission, to Cambodia as part of the United Nations Transitional Authority in Cambodia (UNTAC). While there he experienced the “sickly sweet smell of decaying bodies, garbage, excrement, [and] filth,” toured the killing fields of Pol Pot, and, on one occasion, had a rocket-propelled grenade pointed at the window of his truck. Yet, in spite of the harrowing moments he faced in Cambodia, it was during his second UN mission in 1995-1996 as part of the United Nations Mission in Haiti (UNMIH) that he began “a new life” as a result of mental trauma.

Westholm’s trade is a unique one in the CAF, something known as Combat Service Support (CSS). A CSS soldier must be able to conduct highly delicate technical tasks directly in

¹ Westholm, Barry. Interview by author. Telephone. Toronto, July 30, 2014.

² Ibid.

³ Vehicle technicians in the Canadian Forces are expected to be both technician and soldier, with their role changing based on the tactical situation.

the line of, or under enemy fire, and be prepared to “join the fight” at a moment’s notice. On numerous occasions, a CSS soldier has to operate independently or in a team of two, far away from committed military (infantry) support. As a CSS vehicle technician, Westholm’s duties in Haiti included, among other things, operating a wrecker to repair, extricate, and return damaged military equipment to base. On one fateful day he received a call to drive to Île de la Gonâve, a small island off the Haitian coast, to help move two UN trucks mired on the island’s only causeway and blocking access to a vital port.⁴ Westholm’s task began as a quintessential CSS mission – a crew of two people (Westholm the crew commander) dispatched kilometres away from their base to provide support to two damaged and mired vehicles. While traveling along the island’s unstable shore, Westholm’s truck sank directly into the mixture of coral and pebbles, rendering it immobile. Thinking still of his directive, he bargained with some of the island’s locals to call in the only bulldozer to attempt to extricate his truck. Unfortunately, the local man operating the bulldozer was quite drunk, and when he was “tantalizingly close,” drove it into the ocean, leaving Westholm and his colleague in both a metaphorical and literal quagmire.⁵

Now, with their island’s only bulldozer in the ocean, many locals began gathering, some seething with anger, and armed with rocks and machetes. With only one comrade present, Westholm worried about their chances of leaving the situation unscathed, or even alive. Believing they were in imminent danger, he sent his colleague to seek help from nearby American troops. He was now alone with only a nine-millimetre pistol and ten bullets to defend his equipment and himself. In his own words, Westholm felt like “prey with wolves around me.” As the crowd closed in he engaged in banter with the group’s de facto leader, attempting to keep the conversation light-hearted and downplay his anxiety. Although outwardly calm, he now

⁴ A predominantly barren and hilly island, Île de la Gonâve was often a hiding spot for runaway slaves during the French colonial period.

⁵ Westholm interview.

believed he was “looking at a medieval type of death,” and mulled over his options. Given the crowd’s size and his limited ammunition, he believed his chances of survival were small. He thus decided on his final plan: “I was going to shoot the guy I was talking to, and another upstart beside him. Those two were gone ... a third [would be shot] if I could, and then I was going to kill myself.”⁶

With the situation’s grim reality in full focus, Westholm spent – he estimates – almost fifteen minutes trying to keep the angry mob at bay. During that time, he surprisingly found his mind projecting thoughts of childhood Christmases, seeing in “perfect clarity” himself in front of the family Christmas tree in flannel pajamas. He also saw visions and memories of his own son, occurring simultaneously with his thoughts of family Christmas as he attempted to negotiate for his life. Back in real time, he considered what condition his body would be in when discovered by UN troops, “if they discovered it.” Westholm rested his hand near his pistol’s grip, leaving the hammer cocked, and safety off. With the tension now at its highest point, he locked eyes with the group’s leader and began to pull out his sidearm to execute his final, desperate act: kill as many of the group’s aggressors as possible and then commit suicide, to avoid being beaten, hacked, and possibly burned to death. It was the last decision he felt he would ever make. Then, just at the moment when he had made peace with the finality of his predicament, United States Special Forces and Canadian troops appeared in the distance, bringing with them enough equipment and personnel to scatter the angry locals, de-escalate the situation, and save Westholm’s life. Still thinking about his original mission, Westholm proceeded to pull his truck out of the sunken shore. He eventually extricated the UN vehicles and unblocked the island’s causeway, which nonetheless was left heavily damaged by the work. Mission accomplished and broken vehicles in tow, he made his way towards the United States Army landing craft to return

⁶ Ibid.

to the main island of Haiti and home base. Feeling relieved about his last minute rescue, he arrived back at the Canadian camp at about 11pm. Knowing the situation back on Île de la Gonâve was still volatile, with an angry populous, a damaged causeway, and a bulldozer in the ocean, Westholm briefed his platoon commander of the incident and shortly after went to sleep.

Several hours later, at 2:15am, Westholm was woken by his captain, who asked him if the earlier incident might have been one of the causes of a riot currently in progress. Westholm replied in the affirmative, upon which time his captain left. Sitting up in his bunk, he began to think about the hitherto unprocessed events of the previous day. Now, unshielded by the adrenalin that had propelled him through the encounter, the flood of thoughts and emotions about his near death at the hands of the angry mob hit him like a strong punch to the stomach. The concurrent thoughts which he had processed with such clarity on Île de la Gonâve now overwhelmed him, and he began to vomit. Westholm recounted: “I staggered out of that tent and went right to the portable toilet and puked my guts out, and sat there shaking like a leaf, like ‘wow,’ because I could not process the amount of stuff that had happened out there, and the officer when he came in had brought it all to the forefront.”⁷

Westholm felt tired the next day, but carried on with his duties. Then, the next night while asleep, his mind went back to Île de la Gonâve and he relived the entire event again, waking screaming at approximately 2:15 the following morning. He leapt from his cot and began to vomit again. Almost twenty years later, as I interviewed him, Westholm recalled waking up at 2am many nights for years, like a programmed alarm clock. Despite the harrowing nature of the causeway incident, upon arriving back in Canada, Westholm chalked up his anxiety to the difficulties of the job. Nonetheless he began to notice a severe degradation in his mental capacity. His short-term memory was significantly reduced, as was his ability to multitask and

⁷ Ibid.

focus. He became worried. He assumed his issues were connected to his “high impact job,” the handling of chemicals as a mechanic, and the physical stresses involved, including those of being a paratrooper, with its intense physical training. Over the next several years, his symptoms, including sleeplessness, nightmares, intense anxiety, and feelings of fight-or-flight (“Why am I scared at the mall?”) caused him to seek help from military physicians and psychologists on numerous occasions. He was given a MRI, CT scan, and other tests for physical injuries, but no definitive diagnosis was made. By 1999, after much “disjointed” support, feeling exhausted and frustrated at having made no headway, Westholm said “fuck it,” and attempted to cope as best he could on his own, immersing himself completely in work and avoiding the problems that plagued his mind. In his own words, “The military became my crutch ... All I really did was military, military, military ... Everything else was sort of put on the sideline.”⁸ Ultimately, he did what numerous colleagues would do – and have done – in his situation: “soldier on.” It was not until 2007, a full twelve years after the incident, that he was finally diagnosed: Post-Traumatic Stress Disorder.

Historical Connections

Although Westholm’s experiences are unique in many respects, they are also representative of the history – hitherto untold – of psychological trauma in the Canadian Forces after the Cold War.⁹ That history was shaped by several factors: First, by individual soldiers like Westholm, and other men and women – both prominent and unknown – affected firsthand by the way PTSD was viewed by rank-and-file soldiers, military leaders, politicians, and Canadian society during the late twentieth century; it was also a history formed by institutions, including of

⁸Ibid.

⁹ Note about terminology: Given that “trauma” can also refer to physical injury to the body, it is important to note that “trauma” in this dissertation refers only to psychological trauma.

course the CAF, but also Canadian psychiatry and journalism; and finally, at a social level, it is a story about the socio-economic outcomes of trauma, consequences encapsulated in PTSD, a disorder with numerous links to historical manifestations of overwhelming anxiety.

Westholm's journey from health to illness and the familiar journey of numerous other CAF members during the 1990s and 2000s illuminate some of the key issues this thesis addresses: First, a general lack of understanding within CAF ranks during the 1990s about what PTSD and psychological trauma were, a dearth of knowledge reflected by the attributing of PTSD's myriad symptoms to physical rather than mental injury. In some cases, troops and leaders expressed outright denial about the possibility of psychological injuries. Secondly, Westholm's difficulties resulted from a military culture that instilled a highly masculinized warrior ethos, emphasizing the physical prowess, stamina, and bravery of its members, thus stigmatizing physical or mental weakness. Thirdly, and connected to this ethos, were the socio-economic implications that affected anyone who presented mental difficulties; implications that often resulted in, at best ostracism, and at worst release from the CAF. Lastly, those released from the CAF sometimes found their career terminated before pension eligibility, meaning their post-service life began with ongoing illness and no pension or compensation for service-related injuries.

For soldiers afflicted with psychological injuries, their diagnosis was as much a *social* and *economic* issue as a medical one, and was subject to larger factors beyond their control. Psychological trauma, and PTSD, trauma's most well known manifestation, became prominent issues in the CAF and Canadian society during the 1990s and 2000s, but its appearance has a longer history, and it is one that has been shaped by military exigencies, medical and political interests, gender norms and expectations, and individual soldiers' experiences.

Writing in the late twentieth century, historian of military psychiatry Hans Binneveld opined that, “One can no longer imagine a battlefield without psychiatrists and psychologists.”¹⁰ Retrospectively, Binneveld’s assessment of the now inseparable link between the mental health profession and the military was somewhat prescient. The final decades of the twentieth century, in particular the 1980s and 1990s, saw the growth of a “culture of trauma” that made PTSD – a disorder defined by the American Psychiatric Association in 1980 – a hotly debated topic in military circles, medical journals, and newspapers across the Western world.¹¹ PTSD thus became a considerable concern for military leaders, as well as for the civilian governments they reported to. But such was not always the case. Throughout the twentieth century, psychological trauma oscillated between being a prominent subject and then at other times a focus only for specialist medical researchers. Ultimately, major conflicts like the two World Wars and Vietnam were the key catalysts that repeatedly brought trauma back into the public eye.¹² The conceptualization of trauma and dissemination of research were predominantly forged and reignited by the fires of war and, in the case of peacekeeping nations like Canada, by “military operations other than war.”¹³

Trauma, Medicine, and History

Standing at the crossroads of psychiatric, military, gender, and cultural histories, mental trauma provides historians a window into the societies and individuals affected by it, as well as the authorities who attempt to explain its myriad manifestations. Since trauma was first

¹⁰ Hans Binneveld, *From Shell Shock to Combat Stress: A Comparative History of Military Psychiatry*, trans. John O’Kane (Amsterdam: Amsterdam University Press, 1997), 1.

¹¹ Ben Shephard, *A War of Nerves: Soldiers and Psychiatrists, 1914-1994* (London: Pimlico, 2002 [2000]), 385.

¹² *Ibid.*, passim.

¹³ Allan English and Sydney Dale-McGrath, “Overcoming Systemic Obstacles to Veteran Transition to Civilian Life,” in Alice Aiken and Stéphanie Bélanger, eds., *Beyond the Line: Military and Veteran Health Research* (Montreal & Kingston: McGill-Queen’s University Press, 2013), 257.

systematically studied in the nineteenth century, medical knowledge, patient experiences, and societal views of trauma have been refracted through different prisms, each shaped by cataclysmic events such as the First World War. Given the sheer scale and number of collectively traumatic events throughout the twentieth century, it is, historians Mark Micale and Paul Lerner remarked, “scarcely surprising that trauma has emerged as a highly visible and widely invoked concept.”¹⁴ By the late twentieth and early twenty-first century, conceptualizations of trauma escaped from the pages of medical journals and entered popular culture, becoming not just a clinical entity, but also a metaphor for life’s struggles.¹⁵ Thus, to trace the history of trauma is to trace the vicissitudes of a chaotic world and humanity’s moral failings. Discussions of exactly what constitutes “trauma” and its biological, psychological, and social effects have led to protracted and widely publicized controversies across the Western world.

Although physicians first became interested in trauma during the 1870s, it was not until a century later, with the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980 that the American Psychiatric Association (APA) officially recognized an entity called “Post-Traumatic Stress Disorder (PTSD).”¹⁶ The timing was no coincidence. Coming on the heels of the Vietnam War and its divisive effect on American society, PTSD’s official recognition was due in large part to the lobbying efforts of antiwar psychiatrists, lay activists, and alienated veterans.¹⁷ PTSD located Vietnam veterans’ baffling postwar symptoms in external events caused by war and social alienation, thus “promising to free individual

¹⁴ Mark Micale and Paul Lerner, “Trauma, Psychiatry, and History: A Conceptual and Historiographical Introduction,” in Micale and Lerner, eds., *Traumatic Pasts: History, Psychiatry, and Trauma in the Modern Age, 1870-1930* (New York: Cambridge University Press, 2001), 1.

¹⁵ Ibid.

¹⁶ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (Washington, D.C.: American Psychiatric Association, 1980), 236-239.

¹⁷ Wilbur Scott, “PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease,” *Social Problems* 37, no. 3 (1990): passim.

veterans of the stigma of mental illness, and guaranteeing them (in theory, at least) sympathy, medical attention, and compensation.”¹⁸ Although initially tailored for Vietnam veterans, over the succeeding decades the PTSD concept created a “consciousness of trauma” in Western society, bridging the gap between civilian traumas such as rape and natural disasters, and the traumas of war.¹⁹ Trauma’s psychological effects had hitherto been intermittently explored, usually during and after major wars, but most researchers lost interest as each war’s memory faded and its veterans were absorbed into the postwar economy. Official recognition of a disorder called PTSD, on the other hand, allowed sustained and targeted studies into trauma’s causes, which proved a “tremendous boon” to clinical research in the human sciences.²⁰ Popular interest in trauma followed suit. As the 1980s progressed, an enormous medical literature about PTSD developed, and academic societies were created to share research.²¹ But despite the fact that PTSD’s recognition quickly led to medical interest in trauma, it was war trauma, and in the Canadian case peacekeeping trauma, that captivated the public and made PTSD an enduring subject of discussion.

History, War, and Memory

Clinical discussions of trauma in the 1980s and 1990s dovetailed with historical reappraisals of, and new approaches toward, past conflicts – most notably the First World War. Beginning in 1975, Paul Fussell’s *The Great War and Modern Memory* explored the way British

¹⁸ Micale and Lerner, “Trauma, Psychiatry, and History,” 2.

¹⁹ Shephard, *A War of Nerves*, 355, 385; Studies of war trauma in the 1980s dovetailed with an increasing interest in studying civilian traumas such as sexual abuse. The publication of psychiatrist and author Judith Herman’s *Trauma and Recovery*, based on experience working with sexual and domestic abuse victims, provides an excellent example of the bridging of the gap between civilian and war trauma. See Judith Herman, *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror* (New York: Basic Books, 1992).

²⁰ Micale and Lerner, “Trauma, Psychiatry, and History,” 2.

²¹ The best example of this was the 1985 creation of the International Society for Traumatic Stress Studies, a collection of researchers from around the world who meet to share research, clinical findings and strategies, and discuss theoretical knowledge on trauma.

soldiers on the Western Front utilized literary traditions to understand and cope with the horrors of modern war.²² Himself an American ex-infantry officer wounded during the Second World War, it was fitting that Fussell was first to investigate how the Western Front was “remembered, conventionalized, and mythologized” by its participants.²³ He argued that the Great War was such an overwhelming experience for its combatants that it gave rise to a new, modern form of understanding; one that was essentially ironic.²⁴ Soldiers’ experiences of the Somme and Passchendaele altered ideas of modern “progress” and changed forever the way war was conceptualized.

Fussell’s study was partly stimulated by his interest in past soldier-authors’ experiences, which helped him to answer the very personal question, “Was my war unique, or merely commonplace and barely worth special notice?”²⁵ Written while the Vietnam War raged, his book moreover was meant to demonstrate to American readers some of the “psychological and intellectual dimensions of ‘combat.’”²⁶ By exploring the traumatic nature of war on its participants, he hoped “that the effect of the book ... might persuade them [Americans] that even Gooks had feelings, that even they hated to die, and like us called for help or God or Mother when their agony became unbearable.”²⁷ Fussell’s literary history of war, modernity, and memory set the stage for future examinations of the construction of social memory. Responses to Fussell’s work, notably Jay Winter’s *Sites of Memory*, *Sites of Mourning*, and in the Canadian context Jonathan Vance’s *Death So Noble*, contributed to a novel analysis of how collective war

²² Paul Fussell, *The Great War and Modern Memory* (New York: Oxford University Press, 2013 [1975]); Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War* (London: Palgrave Macmillan, 2013 [2002]), 182.

²³ Fussell, *The Great War and Modern Memory*, xv.

²⁴ *Ibid.*, 38.

²⁵ *Ibid.*, 363; For more on Fussell’s personal experiences readers can also direct themselves to popular American documentarian Ken Burns’ multi-episode series *The War*, which utilized candid interviews with Fussell.

²⁶ *Ibid.*, 369.

²⁷ *Ibid.*

trauma both forms and disrupts constructions of national identity and memory.²⁸ All three works demonstrated that in the search for a unified collective remembrance, literal and metaphorical traumas often clash with ideas of the “good war” and myths about a war’s purpose.²⁹ This dissertation expands on their analyses, highlighting how in Canada the traumatized veteran has been the living embodiment of the gritty, brutal, and harrowing nature of war and peacekeeping; a representation repeatedly at odds with collectively sanitized narratives tied up in medical and political projects. Traumatized soldiers’ experiences provide an inroad into how national identities and social memories are shaped, and equally important, how such beliefs conflict with the everyday struggles veterans face upon their return to civilian life.

War, Society, and Masculinity Studies

As scholars reappraised ideas of war and memory, a concurrent literature exploring the historical shaping of masculinity developed in the 1990s and 2000s. Although taken up largely by male historians, it was a woman who first investigated the subject of war, psychiatry, and masculinity in significant depth. Elaine Showalter’s 1985 work *The Female Malady* uncovered historical representations of “feminine madness and masculine rationality,” and devoted an entire chapter to discussing how shell-shocked soldiers presented a challenge to English psychiatry and notions of manliness during the First World War.³⁰ Her book was a stinging feminist critique of British psychiatry and she extended her gender analysis to how masculinity itself was pathologized using feminine constructs. Showalter argued the war was “a crisis of masculinity

²⁸ Jay Winter, *Sites of Memory, Sites of Mourning: The Great War in European Cultural History* (Cambridge: Cambridge University Press, 1995); Jonathan Vance, *Death So Noble: Memory, Meaning, and the First World War* (Vancouver: UBC Press, 1997); Another noteworthy study that examines collective memory is Canadian historian Robert Rutherford’s 2004 monograph *Hometown Horizons*. See Robert Rutherford, *Hometown Horizons: Local Responses to Canada’s Great War* (Toronto: UBC Press, 2004).

²⁹ See Vance, *Death So Noble*, esp. 3, 18, 260-261.

³⁰ Elaine Showalter, *The Female Malady: Women, Madness, and English Culture* (New York: Pantheon Books, 1985), 2, 167.

and a trial of the Victorian masculine ideal.”³¹ In her view, numerous men were placed in overwhelmingly stressful situations and reacted with “the symptoms of hysteria,” a “feminine” disorder.³² As the war progressed psychiatrists explored the possibility that men’s problems had origins that might be more deeply rooted in their psyches than previously understood; a possibility that had a profound impact on conceptualizations of trauma throughout the rest of the century.³³

Showalter’s work was the first to critically examine how psychiatric knowledge both shaped and was coloured by masculine ideals during wartime. Her discussion went beyond strictly medical concerns, highlighting the socio-cultural aspects of war trauma and the medical theories underpinning it. By situating “shell shock” in a particular time and setting, her book provided further impetus for scholars to reappraise medical categories and use a cultural lens to deconstruct how experiences of trauma and gender conflicted with one another.³⁴

Historian of gender and psychiatry Mark Micale’s 2008 work *Hysterical Men*, which tracked hysteria’s conceptualization across the centuries, highlighted the socio-political and

³¹ Ibid., 171.

³² Ibid; Shell shock was, she stated, men’s bodily protest against a lack of control imposed on them by politicians, generals, and psychiatrists. See ibid, 172.

³³ Ibid., 190.

³⁴ Drawing inspiration from gender studies, scholars readily responded to Showalter’s feminist analysis of psychiatry and began examining the historical construction of modern masculinity that developed in the West. American cultural historian George Mosse’s 1996 work *The Image of Man*, which traced the rise of modern masculinity, signalled a new, incisive assessment of how masculinity “touched nearly every aspect of society.” Mosse provocatively stated that “All those who want to change society, as well as those who want to escape their marginalization, have to take the stereotype of modern masculinity into account.” A concept previously taken for granted, exactly what constituted masculinity, and how that definition changed at any given time, were increasingly placed under the gaze of historians seeking to unravel its many effects and meanings. See George Mosse, *The Image of Man: The Creation of Modern Masculinity* (New York: Oxford University Press, 1996), 194, 3, 278, 6; In the Canadian context, during the 1990s historians likewise analyzed how societal expectations, and particularly gender expectations, have been shaped by medico-psychological dictates. Mona Gleason’s 1999 book *Normalizing the Ideal* provided a thorough critique of how “normalcy” and the “normal” post-1945 Canadian family were constructed through psychological knowledge and dissemination. While psychiatry focused on emotional and behavioural pathology, postwar psychologists proclaimed themselves authorities on what constituted normal family living. See Mona Gleason, *Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada* (Toronto: University of Toronto Press, 1999), passim; Mark Moss’ *Manliness and Militarism* is another notable work. See Mark Moss, *Manliness and Militarism: Educating Young Boys for War in Ontario* (Don Mills, Ont.: Oxford University Press, 2001).

medical discourses that created a willful blind spot in the minds of physicians afraid to acknowledge male nervous illness.³⁵ Scared that men were not the paragons of rationality which centuries of intellectual thought had claimed, medical men “failed to constitute their own gender as a field of critical, systematized study.”³⁶ That failure was, Micale stated, all the more surprising given the “rampant counter-evidence [about male nervous illness] in the clinic and the laboratory, on the streets and the battlefields.”³⁷ Physicians’ refusal to turn their gaze inward reflected a fear that male hysteria could uncover “feminine” elements within the male psyche.³⁸ To be self-aware was thus deemed an “unmasculine” quality.³⁹ Micale uncovered men’s “chronic inability to reflect nonheroically, without evasion and self-deception, on oneself individually and collectively;” a failure that had lasting effects on interpretations of shell shock during the First World War, an affliction contemporaries frequently compared to hysteria.⁴⁰ Micale’s work displayed the highly gendered manner in which psychiatric thought and practice operated throughout the nineteenth and early twentieth century. Importantly, *Hysterical Men* showed that it was only late in the twentieth century that medicine no longer played “a commanding role in producing the dominant fictions of masculinity.”⁴¹

³⁵ Mark Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, Mass.: Harvard University Press, 2008); In a testament to Showalter’s enduring influence on the field, Micale’s prologue was titled “Hysteria: The Male Malady,” in his own words as a respectful nod to Showalter’s “important book.” See *ibid.*, 288n6.

³⁶ *Ibid.*, 278.

³⁷ *Ibid.*, 6.

³⁸ *Ibid.*, 281.

³⁹ *Ibid.*

⁴⁰ *Ibid.*, 282, 139.

⁴¹ *Ibid.*, 284; In the Canadian context Christopher Dummitt’s *The Manly Modern* represented the rise of masculinity studies. Most pertinent to this dissertation, Dummitt explored the unintended consequences of the “manly modern” project, especially how such consequences affected Canadian war veterans. His study highlighted the intricate historical web of medical knowledge, gender expectations, and pension questions, as well as a recurring pattern in Canadian history: the off-loading of long-term financial liabilities at the expense of Canadian veterans. See Christopher Dummitt, *The Manly Modern: Masculinity in Postwar Canada* (Toronto: UBC Press, 2007), 2, 4, 29-51, 40; Recent works such as the 2014 book *Ontario Boys* by Christopher Greig, and the 2012 edited collection *Canadian Men and Masculinities* by Greig and Wayne Martino, display Canadian scholars’ continuing efforts to analyze the enduring effects of masculine norms on both individuals and society. See Christopher Greig, *Ontario Boys: Masculinity and the Idea of Boyhood in Postwar Ontario, 1945-1960* (Waterloo: Wilfred Laurier Press, 2014);

Discussions of war's effects on societal norms and culture were broadened by the rise of trauma as a tool of historical analysis. Since the 1980 codification of PTSD as a mental disorder, scholars from several historical subfields (and other disciplines) have attempted to piece together the social, medical, and cultural meanings of trauma.⁴² With the rise of trauma debates in Canadian medical and popular culture, particularly in the 1990s and after, there was a concurrent rise in the number of historical studies linking contemporary ideas of trauma with earlier medical manifestations like shell shock.⁴³ Prior to 1990 one looks in vain for mentions of PTSD in Canadian historical studies. For example, Tom Brown's 1984 essay "Shell Shock in the Canadian Expeditionary Force" highlighted the links between the shell shock "epidemic" during the First World War and the professional development of psychiatry and psychology, but made no mention of PTSD.⁴⁴ Terry Copp and Bill McAndrew's groundbreaking 1990 monograph *Battle Exhaustion*, which explored military psychiatrists' efforts to treat battle exhaustion in the Canadian Army during the Second World War, made only one brief mention of "Post-traumatic

Greig and Wayne Martino, eds., *Canadian Men and Masculinities: Historical and Contemporary Perspectives* (Toronto: Canadian Scholars' Press Inc., 2012).

⁴² Micale and Lerner, "Trauma, Psychiatry, and History," 6; By the new millennium, historians' interest was self-evident. Ben Shephard's 2000 book *A War of Nerves*, Mark Micale and Paul Lerner's 2001 edited collection *Traumatic Pasts*, and Edgar Jones and Simon Wessely's 2005 work *Shell Shock to PTSD*, all three of which trace the history of psychological trauma across broad timeframes and places, were demonstrative of expansive growth in the trauma history field. See Micale and Lerner, *Traumatic Pasts*; Ben Shephard, *A War of Nerves*; Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War* (New York: Psychology Press, 2005); See also Binneveld, *From Shell Shock to Combat Stress*.

⁴³ In the United States, where the PTSD concept originated, this trend happened slightly earlier. For one early example that mentions PTSD in connection with earlier battlefield disorders see Richard Gabriel, *No More Heroes: Madness and Psychiatry in War* (New York: Hill and Wang, 1987), 77, 157.

⁴⁴ Tom Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War," in Charles G. Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Hamilton: McMaster University, Hannah Institute for the History of Medicine, 1984), *passim*.

stress syndrome.”⁴⁵ Nonetheless, that mention was crucial because it was the first time Canadian historians linked post-1980 conceptions of trauma and earlier battlefield manifestations like shell shock and battle exhaustion.⁴⁶

Reflecting the gradual influence of trauma studies on historical writing, Terry Copp’s 1998 essay on post-World War Two veterans’ psychological illness traced the subject’s history from shell shock “to Post-Traumatic Stress Disorder.”⁴⁷ Copp acknowledged the rise of trauma research and discussions in Canadian print media amidst the numerous peacekeeping operations of the 1990s, calling PTSD research a “growth industry.”⁴⁸ A later 2010 edited collection by Copp and Mark Humphries about combat stress in Commonwealth soldiers across the twentieth century showed that by the new millennium views about the universal nature of trauma had caused scholars to re-think shell shock, battle exhaustion, and PTSD. Each manifestation was now viewed as an amorphous example of a similar and timeless phenomenon. Debates and controversies ensued.⁴⁹

⁴⁵ Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939-1945* (Montreal & Kingston: McGill-Queen’s University Press, 1990), 157; Copp’s 1992 essay on the development of neuropsychiatry in the Canadian Army during World War Two made no mention of trauma or PTSD at all. See Copp “The Development of Neuropsychiatry in the Canadian Army (Overseas) 1939-1943,” in C. David Naylor, ed., *Canadian Health Care and the State: A Century of Evolution* (Montreal & Kingston: McGill-Queen’s University Press, 1992), 67-84.

⁴⁶ To the best of my knowledge.

⁴⁷ Terry Copp, “From Neurasthenia to Post-Traumatic Stress Disorder: Canadian veterans and the Problem of Persistent Emotional Disabilities,” in Peter Neary and J.L. Granatstein, eds., *The Veterans Charter and Post-World War II Canada* (Montreal & Kingston: McGill-Queen’s University Press, 1998), 149-159; Allan English’s 1996 study of Canadian aircrew, which likewise discussed the role of psychologists and psychiatrists, in this case in aircrew selection, training, etc., made just one brief mention of PTSD in a footnote. See Allan English, *The Cream of the Crop: Canadian Aircrew, 1939-1945* (Montreal & Kingston, McGill-Queen’s University Press, 1996), 217.

⁴⁸ Copp, “From Neurasthenia to Post-Traumatic Stress Disorder,” 156.

⁴⁹ See Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), passim, esp. 5-6; By the 2000s, in combination with the aforementioned rise of socio-cultural histories, scholars interested in war trauma created more holistic analyses that examined societal mentalities, the medical profession, and traumatized veterans themselves. Historian Peter Leese’s 2002 *Shell Shock*, about the “mass trauma” of shell-shocked British soldiers and postwar society was an excellent example of the “new” historical trauma research. Leese examined the Great War shell shock phenomenon not just during wartime, but also its post-1918 emergence as a metaphor for the war itself. Leese argued that shell shock was both a medical phenomenon *and* a symbol of collective trauma. Moreover, that symbolism was not static. Put simply, shell shock “changed its meanings to suit the preoccupations of British society through the twentieth century.” See Leese, *Shell*

One seminal study arising from the post-1980 rise of PTSD research, responded to by authors across the Western world since, was Allan Young's 1995 book *The Harmony of Illusions*. Young's controversial thesis suggested that PTSD was not timeless, but instead was "glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented by the various interests, institutions, and moral arguments that mobilized these efforts and resources."⁵⁰ He particularly took aim at the belief that PTSD could be found in many times and places. Instead, he argued that the theory of a traumatic memory, emerging in the nineteenth century and enshrined later in the 1980 PTSD concept, was a modern creation unknown and unavailable to earlier societies. Young did not deny the reality of PTSD, but rather affirmed that PTSD was a separate phenomenon from earlier medical diagnoses like hysteria, brought together by a specific set of medical practices, research, and patients' realities. Nor did he cast doubt on trauma's reality, but instead the expansive diagnosing of PTSD under circumstances not directly related to war, such as feelings of guilt, something not necessarily a part of earlier traumatic phenomena like shell shock. For historians, the most important element of Young's book was that it critically examined clinical practices, trauma theories, and historical negotiations between physicians and patients. His work displayed the importance of understanding how traumatic experiences "penetrate people's life world, acquire facticity, and shape the self-knowledge of patients, clinicians, and researchers."⁵¹

Canadian historical scholarship on war trauma has been influenced by the above authors, but thus far few studies have emerged. Mark Humphries' 2010 article "War's Long Shadow" was the first to combine developments in these subfields to examine Canadian veterans'

Shock, 184, xiii, 3; Another noteworthy example was Peter Barham's *Forgotten Lunatics*. See Peter Barham, *Forgotten Lunatics of the Great War* (New Haven: Yale University Press, 2004).

⁵⁰ Young, *The Harmony of Illusions*, 5-6.

⁵¹ Ibid.

experiences of postwar trauma and pension concerns from medical, gender, and socio-political perspectives.⁵² But in spite of Humphries' initiative, little has since followed it. Copp and Humphries' edited collection brought together a vast array of historical documents and perspectives, but their exploration of war trauma in Canada does not thoroughly address post-1980 developments, and it does not appraise Canada's challenges with peacekeeping trauma after the Cold War.⁵³

Since the 1980s Canadian military historians have led the charge to explore psychological trauma in Canadian history, but the aforementioned studies have largely focused on the First and Second World War, and no book-length study about Canadian experiences across the twentieth and early twenty-first century has been attempted.⁵⁴ Moreover, aside from Humphries' article, no Canadian historian has produced a comprehensive analysis of war trauma which utilizes developments in the gender and cultural history subfields.⁵⁵ Previous works, which illuminated medical practices and theories of psychological trauma during and immediately after wartime, centred more on physicians than patients.⁵⁶ With regard to peacekeeping experiences, there have been even fewer attempts to explore trauma's effects on individual peacekeepers and Canadian conceptions of national identity. Journalist Carol Off's 2004 book *The Ghosts of Medak Pocket*, about Canadian peacekeeping experiences in the Balkans during the 1990s, is one of the only book-length studies that examines peacekeeping trauma, and then only tangentially.⁵⁷ Likewise

⁵² Mark Humphries, "War's Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914-1939," *The Canadian Historical Review* 91, no. 3 (2010): 503-531.

⁵³ Their work reproduced several peacekeeping trauma studies, but did not discuss them in a historical perspective. This was most likely because, as its title suggested, it was concerned primarily with *combat* stress, something peacekeeping has traditionally been excluded from.

⁵⁴ Some of the sources cited throughout this dissertation discuss historical elements of trauma, but most are within military journals and thus focus on trauma vis-à-vis the military. Others likewise discuss elements of trauma history, but approach the subject from a strictly strategic or medical perspective.

⁵⁵ To the best of my knowledge Humphries' 2010 article is the only Canadian academic article of its kind.

⁵⁶ See above works by Copp, McAndrew, and Brown.

⁵⁷ Carol Off, *The Ghosts of Medak Pocket: The Story of Canada's Secret War* (Toronto: Random House of Canada, 2005 [2004]).

political scientist Sandra Whitworth's 2004 book *Men, Militarism & UN Peacekeeping* presented a critique of UN operations and explored the gendered elements of peacekeeping relations, but trauma was relegated to only a small section of her larger narrative.⁵⁸

New Opportunities

Taking advantage of a unique and “open” moment in Canadian military history, this study traces how trauma has been interpreted by the military, Canadian society, and the individuals affected by it. At the cultural level, this dissertation is an examination of how physicians and patients entered into a dialogue of ideas about how trauma was constructed and understood at the experiential level. It is also a history of the socio-politics of trauma. This story draws heavily from the concerns expressed by soldiers traumatized by war and peacekeeping operations, and explores their economic motives and contributions to national identity.

PTSD and conceptions of trauma changed over time; tracking these changes reveals medical and cultural shifts in consciousness against the backdrop of military operations. Although medical knowledge and societal attitudes toward psychological trauma shifted from the early twentieth to early twenty-first century, stigmas about the mentally ill veteran persisted, as did the socio-economic troubles that dogged veterans as they reintegrated into civilian life. While the general trend was one of increasing understanding and sympathy, veterans from the First World War through to those returning from Afghanistan shared many of the same socio-economic challenges. Indeed the language of illness and the shame associated with it remained consistent despite any changes in military operations, medicine, or technology. Although shifts

⁵⁸ Sandra Whitworth, *Men, Militarism, & UN Peacekeeping: A Gendered Analysis* (London: Lynne Rienner Publishers, 2004); Whitworth subsequently followed this work with a 2008 essay that further explored the subject. See Whitworth, “Militarized Masculinity and Post Traumatic Stress Disorder,” in Jane Parpart and Marysia Zalewski, eds., *Rethinking the Wo/man Questions in International Relations* (London: Zed Books, 2008), 109-126.

in psychiatric theory and orientation after 1980 helped to formally recognize veterans' mental suffering, the clinical road to recovery often neglected the socio-economic realities of postwar and civilian life.

Soldiers' battles with traumatic events symbolize the nation's struggle to reconcile its complex history, one that has made Canadians both battle-tested warriors and harbingers of peace in troubled areas of the globe. The plight of veterans, and how Canadians rationalize their plight, represents society's attempts to honour and memorialize noble deeds, as well as to forget about the darker periods in our national tapestry. Historically, veterans' experiences were accepted or discarded amidst the construction of social memories based on a "combination of invention, truth, and half-truth."⁵⁹ But even when unpalatable or inconvenient to prevalent societal views, their experiences refused to be fully submerged. Ultimately the traumatized veteran, whether afflicted with "shell shock," "battle exhaustion," or "PTSD," represented the dangerous, unflinching, and enduring legacies of military operations across many times and places.

This dissertation contributes to discussions of trauma and military history in a few key respects. First, it engages with debates about how trauma is experienced across different eras, showing that although certain manifestations of trauma, such as persistent nightmares, were common to every era, shell shock and its successors were rooted in particular times and places.⁶⁰ Like Peter Leese, and Allan Young before him, I view each trauma manifestation as a similar but distinct "idiom of sickness."⁶¹ Put simply, PTSD is just another representation of trauma in a continuing cultural and medical project that aims to bring trauma's numerous social and medical

⁵⁹ Vance, *Death So Noble*, 8.

⁶⁰ Allan Young made a particularly strong case in this regard with his discussion of the traumatic memory, a cultural creation of the nineteenth century. The print media is especially guilty of sometimes still interchangeably using "shell shock" and "PTSD."

⁶¹ Leese, *Shell Shock*, 31.

effects under a neatly encapsulated umbrella.⁶² Exploring each phenomenon in its own right provides a greater penetration of socio-cultural trappings and allows historians to see the complex connections between individual lived experiences, medical theories, and societal views and representations; essentially spotlighting the shadowy realms that trauma experiences reside in. Historically, each trauma manifestation was an individual illness, but together they symbolized a particular view of war, and in the Canadian case, peacekeeping, as well as the way conflicts were retrospectively seen by society. By examining trauma thus, this dissertation brings the Canadian experience across the *longue durée* into international discussions of trauma history, something not yet attempted by Canadian historians in a monograph-length study.

Equally important, this dissertation also adds to an incipient trauma history field in Canada, bringing together military, medical, and social histories. Veterans' experiences speak volumes about the social experience of trauma, and from a cultural standpoint, about the construction of masculinity and its intimate ties to military culture. The military represents one of the last bastions of "traditional" masculinity; as such, exploring its connections to issues like trauma opens up further opportunities for understanding how military culture interacts with and shapes medical and lay perspectives on illness. Most importantly, this study heralds a lengthy examination of how trauma and peacekeeping both intermingled and conflicted with medical theories and cultural discussions after the Cold War; again something no Canadian historian has yet attempted beyond article-length studies. By bringing the historical narrative into the late twentieth and early twenty-first century this project opens up new avenues for future researchers and demonstrates the benefits of a comparative, multifaceted approach to the history of trauma in the military and Canadian civilian society. It also opens up opportunities for comparative

⁶² In philosophical terms, it is a medical project that consistently attempts to defy Johann Wolfgang von Goethe's dictum that "All theory, dear friend, is gray, but the golden tree of life springs ever green."

histories to further analyze “universal” experiences of trauma, moving beyond the idiosyncratic experiences of veterans and into comparisons of military and civilian trauma in Canada.

Chapter Structure

This dissertation is divided into six chapters, each revolving around a particular war or peacekeeping mission. War, and the act of peacekeeping, heralded the rise of popular discussions about psychological trauma in Canada. While civilian trauma captured the attention of medico-psychological researchers beginning in the 1870s, it was the strain and horror of military conflicts that haunted numerous men and brought their mental troubles into popular consciousness. Shell shock, battle exhaustion, and PTSD were and continue to exist as real entities, but the symptom patterns, patient experiences, and medical terminology were shaped by historically contingent socio-cultural and political factors.⁶³

The first chapter examines organized medicine’s interest in psychological trauma from the 1870s through to 1914, and explores the Canadian Army’s experience with shell shock during the First World War. Medical theories about shell shock evolved alongside popular conceptions of manliness and proper soldiering; these ideas coincided with Canadian psychiatry and psychology’s early professionalization efforts. Shell shock became in many respects a metaphorical battleground on which differing medico-psychological theories competed with one another, before psychological theories explaining trauma gradually took precedence over organic, physical ones. Utilizing contemporary medical literature and newspaper sources like the *Globe*, the opening chapter shows how popular sympathies toward shell-shocked soldiers clashed with medical and military dictates that deemed such behaviour illegitimate and feminine. After the war, physicians were the gatekeepers of pensions, and believed in the importance of a pull-

⁶³ See above cited works; namely Young and Leese, as well as Jones and Wessely.

up-your-bootstraps work ethic. Those unable to adapt to postwar life were viewed as weak, effeminate, and undeserving of compensation. Thus physicians successfully denied numerous shell-shocked veterans pensions, supposedly for their own good.

Drawing on a combination of contemporary literature, newspaper sources, and a firsthand account by author and veteran Farley Mowat, Chapter two discusses the Canadian Army's experience with "battle exhaustion" during the Second World War. Allied military psychiatrists attempted to prevent another shell shock epidemic by bringing battlefield trauma and psychological difficulties under the all-encompassing term of "battle exhaustion." Ostensibly a transient condition solvable through rest and recuperation, battle exhaustion reflected a shift in medical thinking toward socio-psychological interpretations of war trauma. By the end of the Second World War, a general consensus developed that every man had his breaking point. But that development was a double-edged sword. If a "neurosis" continued after the war, it was predominantly caused by earlier life events and upbringing. Freudian and other psychodynamic approaches combined to produce a belief among Department of Veterans' Affairs physicians that "neurotic" veterans should not be given pensions. Such men, they believed, must be prevented from shirking their duties as fathers, breadwinners, and leaders of postwar society. Once again numerous veterans were deemed weak, inadequate, and failed men by state-employed psychiatrists heavily influenced by contemporary beliefs about traditional manhood and what battle exhaustion revealed about a man's inherent weakness.

Once again using newspaper sources and contemporary medical literature, chapter three shifts the focus to Vietnam and demonstrates the continuing link between psychiatry and war trauma. The Vietnam War stimulated considerable public discussions about trauma, while the televised and highly visible traumatized soldiers cultivated popular sympathy and frustration

about the impact of war on soldiers' mental state. The war's divisive nature, and the traumas numerous Vietnam vets experienced, dovetailed with a revolution in American psychiatry. In the 1970s a group of biologically, anti-Freudian-oriented APA members campaigned to rewrite the *Diagnostic and Statistical Manual of Mental Disorders*, American psychiatrists' Bible. Their success, culminating in the manual's 1980 third edition, set psychiatry on a vastly different trajectory, one which encouraged greater efforts into targeted and empirical research. Influenced by an eclectic group of radical psychiatrists, war veterans, and trauma researchers, the APA agreed to acknowledge a new conceptualization of trauma – "Post-traumatic Stress Disorder." For the first time psychiatrists officially recognized a consequence of trauma that originated from without, rather than within those afflicted. But given PTSD's socio-political origins, physicians in Canada and elsewhere at first largely dismissed it as an American, Vietnam-specific condition.

Chapter four traces the history of Canada's peacekeeping operations and its contribution to national identity after the 1956 Suez Crisis, primarily through oral interviews with former peacekeepers, government documents, and cultural sources such as newspapers and television broadcasts. By the Cold War's end, a specific vision of peacekeeping – characterized by Canadian soldiers gallantly keeping warring factions at bay in a clearly defined zone of separation – took hold. Nonetheless, after 1991 a new type of peacekeeping emerged, one in which combatants respected neither their enemies nor the peacekeepers sent to prevent further bloodshed. The Canadian military and public were psychologically unprepared for the horrific events that occurred in places like the Former Yugoslavia throughout the 1990s. Amidst numerous scandals throughout the decade, most notably the 1993 murder of a teenage boy in Somalia by Canadian peacekeepers, the CAF and Department of National Defence (DND) went into a defensive posture. Politicians and military leaders deemed peacekeeping trauma another

potential scandal, and thus attempted to deny it. Nonetheless, against the backdrop of harrowing military operations and a military culture that stigmatized psychological problems, trauma became a battleground for old and new interpretations of war trauma, masculinity, popular perceptions of peacekeeping, and the nation's role in international politics.

Analyzing transcribed soldiers' testimonies from the Croatia Board of Inquiry (BOI) and oral interviews with Board members and former peacekeepers, as well as correspondence with the Board's former Chairman, the fifth chapter explores the rise of PTSD in the Canadian national consciousness as a result of peacekeeping trauma.⁶⁴ With almost 100 testimonies totalling approximately 2,000 pages, BOI documents and peacekeepers' recollections display soldiers' personal battles with trauma and the vagaries of military culture. Throughout the mid-to late-1990s, a series of prominent events such as Lieutenant-General Roméo Dallaire's public struggle with PTSD, as well as the numerous disclosures of rank-and-file soldiers during BOI testimonies, caused a paradigm shift in views of psychological trauma. Canadian military leaders, politicians, and the general public gradually realized that trauma resulted from peacekeeping as well as war. Moreover, a disorder the general public once deemed a uniquely American veterans' affliction gradually became linked in Canada with peacekeeping trauma, something hitherto unheard of. Publicly broadcast throughout its proceedings in late 1999, the BOI presented a challenge to historically suppressed discussions of men's psychological problems and forced an acknowledgement of the reality of peacekeeping trauma.

Tracing developments through interviews, government documents, news reports, and soldiers' memoirs, the sixth and final chapter discusses the battle between military reformers and an "old guard" after the Canadian Forces' entry into the Afghanistan War in 2001. The

⁶⁴ The chapter also draws on correspondence with former Chairman and Brigadier-General Joe Sharpe, as well as others involved in the events covered.

Canadian experience with trauma after 2001 was particularly instructive in what it revealed about the contingencies of medical categories and the importance of culture in determining the relevance of medical diagnoses. Throughout the early twenty-first century trauma remained a battleground for physicians, military reformers, and public debates about Canada's national identity and role in international affairs. Behind those battles lay the traumatized veteran, a figure who once again demonstrated the importance of socio-economic factors in a soldier's road to recovery. Veterans' experiences showcase the consistent role of trauma as a prism through which to view contemporary social norms, medical knowledge, and cultural anxieties. For all of the changes over the one-hundred-year period covered, the final chapter highlights trauma's continuing existence as both a clinical entity and a metaphor of the nation's struggles to reconcile its national identity and military accomplishments with the traumatic experiences of those serving on its behalf.

Methodology

In bringing together the history of trauma in the Canadian military across unique periods in the nation's development, this dissertation relies on an eclectic array of sources. For tracing medical trends and changes to theory and practice, I have relied heavily on the *Canadian Medical Association Journal*. As a mainstream journal of Canadian medical practices and ideas, and one that has been continuously published across the timeframe this dissertation covers, the *Journal* proved crucial for tracking how and when Canadian physicians discussed trauma, as well as when such discussions faded into relative obscurity throughout the twentieth century. As the official organ of the Canadian Medical Association, the *Journal* is a barometer of mainstream medical opinions, and allows insights into the connection between the state, medicine, and the

military, especially during the First and Second World Wars.⁶⁵ Using physical *Journal* copies, and later online keyword searches, I was able to locate numerous discussions of shell shock, battle exhaustion, and later PTSD. My search involved scanning all article titles from the 1914 to 2000 period, looking specifically for titles that contained the words above and/or mention of “nervous” disorders; or the Canadian military more broadly. Once located, I read through each article and selected them based on whether or not they were of a qualitative (that is, those that spoke to theories of trauma and military/medical policy) or quantitative nature (those that used statistical analysis to report treatment success or failure). For the most part, the former type were utilized since they discussed the themes this dissertation addresses, such as general medical opinions of etiology and the relations of shell shock etc. to past instances of military trauma. These articles allowed a glimpse into medical thoughts on trauma, treatment methods, and the administration of government health initiatives for soldiers and veterans across the *longue durée*.

Other medical journals such as the *Canadian Journal of Psychiatry* (CJP) were similarly useful for providing comparisons and contrasts between medical and cultural representations of trauma, as well as how and *when* trauma became a subject of significant interest for Canadian researchers. As the official publication of the Canadian Psychiatric Association, the CJP likewise provides a unique window into the waxing and waning of medical research topics across the twentieth and twenty-first centuries. Although never as influential or widely read as its American counterpart, the *American Journal of Psychiatry*, the CJP nonetheless displays the concerns and interests of mainstream Canadian psychiatric thought, and thus helps with tracing the rise of trauma as a significant topic for Canadian psychiatrists. Using a similar method as that for the *Canadian Medical Association Journal*, I examined article titles for mentions of trauma and read

⁶⁵ Part of the *Journal*'s importance also lies in the fact that many of its articles were and continue to be published by the leading Canadian medical authorities and researchers.

through each piece, using them as a gauge for how and when trauma was discussed and in what contexts (i.e. civilian or military).⁶⁶

Newspapers add another layer of depth to historical discussions of trauma in Canada, and thus constitute the most important cultural source drawn upon in this dissertation. To capture national, popular narratives over a one-hundred-year period, I have relied extensively on two newspapers with lengthy publication records: one nationally circulated, the *Globe and Mail*, and the other circulated in Ontario, the *Toronto Star*. This choice was made partially due to both papers' long history, continuous publication record, and large circulation figures, and partially for expediency – namely that both papers' archives can be easily accessed in numerous locations in physical print format, microform, and online. As the largest nationally-circulated newspaper, the *Globe and Mail* is a particularly useful source for examining media fascination with and reporting of war trauma, even despite its Toronto-based ownership and reputation among some Canadians as a spokesperson for the “old and male.”⁶⁷ The *Toronto Star* is important because of its reputation for covering “sensitive” topics, e.g. military trauma, and as a barometer of opinion in the densely populated province of Ontario. In both cases, I relied first on physical library searches and later online keyword searches to accumulate notes on approximately 1000 articles on PTSD and its antecedents, stretching from the early twentieth to early twenty-first century.⁶⁸ After concluding my search I collated and selected the articles according to their relevance to my dissertation – e.g. whether or not the article discussed civilian or military trauma, etc. This

⁶⁶ It is important to note that that my search was limited to the 1979 period forward due to journal copies missing from before that date at both the University of Saskatchewan and McMaster University libraries; both libraries being those within a reasonable distance from which to conduct a search. Unfortunately, the CJP's online database does not go back beyond the 1996 period.

⁶⁷ The *National Post* was also consulted on a few occasions, likewise because of its national circulation and because of its coverage of key events covered here.

⁶⁸ The full list of keywords used for both physical and online searches was as follows: “PTSD,” “Post-Vietnam Syndrome,” “Post-Traumatic Stress Disorder,” “Post-traumatic stress syndrome,” “Vietnam Syndrome,” “Traumatic Neurosis,” “Traumatic Stress,” “Stress Neurosis,” “Combat Stress,” “Operational Stress,” “Stress Response,” “Trauma,” “Psychological Trauma,” “Railway Spine,” “Critical Incident Stress.”

lengthy but thorough approach allowed for a clear picture of the rise and fall of newspaper reporting on trauma, and especially military trauma and veterans' issues, over the period covered by this project. It also provided a look at how and when medical theories penetrated popular discourses, and how public discourses on the military and masculinity were discussed in these venues.

In other instances, I selected newspapers' articles according to more idiosyncratic concerns. I utilized the *Ottawa Citizen* primarily because of its consistent (and early) coverage of military trauma in Canada after the Cold War. Long-time *Citizen* reporters David Pugliese and Chris Cobb have both earned a reputation among "insiders" and researchers as incisive and thorough examiners of Canadian military issues; thus their articles often discuss trauma in both contemporary and historical contexts. Pugliese gave an interview for this dissertation and Cobb was helpful for pointing me in the direction of earlier articles on the subject. Both men gave me an "insider's" view of the battle between media investigators, Canadian military leaders, and federal politicians.

Lastly, in regard to newspapers, for a brief but nonetheless important look at medical narratives and discussions of Canada south of the border I relied in a few instances on past issues of the *New York Times*. The *Times* has consistently published discussions of medical developments and military and veterans' issues, including on occasion Canadian topics, and as such adds another layer of analysis, helping place Canadian developments in an international context.

Regarding other Canadian cultural sources such as novels and memoirs, I chose the particularly poignant and widely read accounts of Farley Mowat. Although there are numerous fictional and non-fictional accounts of the First and Second World War by Canadian authors,

there are few that explicitly mention trauma, shell shock, or battle exhaustion.⁶⁹ Mowat wrote extensively and candidly of his war experiences, including how battle exhaustion affected Canadian soldiers in the Second World War, and through oblique mentions of his own father's experiences in World War One, he referenced shell shock as well. His books are one of the only popularly read (and easy to locate) accounts of trauma's effects on Canadian soldiers during the World Wars. When possible, I supplemented this view of early- to mid-twentieth century discussions of trauma with accounts by Canadian and non-Canadian veteran medical officers such as R.J. Manion and Lord Moran. This helps to compare and contrast the medical view with that of the frontline soldier. Thankfully for historians, the increased discussions of trauma in the Canadian military after the Cold War make it much easier to locate book-length narratives of trauma by veterans, the most prominent of which have been used in the sixth chapter.

Methodology – Oral Interviews

My main aim has been to capture as best as possible veterans' lived experiences of trauma and how it affects them not just in a medical sense, but in their daily social lives. In this regard the most important primary source material was oral interviews with members of the Operational Stress Injury Social Support (OSISS) program, a peer-support program for soldiers and veterans with operational stress injuries such as PTSD.⁷⁰ In my search for the lived experiences of CAF members and veterans with psychological injuries, I first sent an e-mail to then OSISS National Program Manager Major Carl Walsh describing my project, asking his help

⁶⁹ One example of fictional Canadian writing about the First World War is that of internationally known author Ralph Connor (1860-1937).

⁷⁰ Here I must acknowledge Copp and McAndrew's *Battle Exhaustion*. Their interviews with former military psychiatrists in the 1980s were one of the first kernels of thought that led to my wondering if I could conduct similar interviews with soldiers and veterans.

on how to proceed.⁷¹ He graciously forwarded my e-mail to Peer Support Coordinators across the country and asked them, should they wish to do so, to spread the word to their local peers. Within twenty-four hours I received several phone calls and e-mails from members willing to speak. Over the next few months I conducted phone interviews with eight OSISS members of various ages and ranks, consisting of seven men and one woman, from various provinces across Canada such as Alberta, Ontario, Quebec, and Newfoundland. Given the sensitive nature of the subject – something that precludes “cold calling” or e-mailing veterans with trauma (or any veterans for that matter) out of the blue – my candidate pool was limited to the number of individuals who contacted me. In addition to the eight interviewees who completed discussions with me, several others initially expressed interest but either got “cold feet” on the arranged interview date or did not respond after initial correspondence. I later learned during the interview process from those who chose to stay the course that this was a common occurrence when speaking with OSISS members, since many were concerned about the career implications of speaking with someone outside the military. It became clear that a perennial fear of discussing military matters with “outsiders” was still prevalent among many within the Canadian Forces, and that mental illness, despite increasing discussions within civilian and military circles, is still a largely taboo subject.

The majority of interviewees were peacekeeping veterans who participated in operations throughout the 1980s, 1990s, and early 2000s. There were also Afghanistan veterans, and a few participated in both war and peacekeeping operations. Our discussions usually lasted between one to two hours, and consisted of initial questions related to biographical information, and then generally became a stream-of-consciousness-style conversation. Each interview began with a series of prepared questions, but I did not attempt to steer any interviewee toward a subject they

⁷¹ Along with this e-mail I sent a one-page consent form outlining my project’s aims.

were hesitant to discuss. I moreover wished to avoid “triggering” any disturbing thoughts or recollections, and to avoid any perception that I was probing for voyeuristic purposes. Thus, I attempted to sense their comfort level and adjust my questions accordingly. In most cases, after questions about their biographical information I let the interviewee direct the flow of conversation, though I tried to keep the discussion on military matters.

The interviews were moving, inspiring, and sometimes emotionally disturbing. In several instances the interviewee had to stop and collect him or herself, and re-listening to the discussions for transcribing purposes turned out to be at times an unexpectedly difficult project for me. In an unflinching manner several interviewees freely related traumatic and harrowing operational events. I was particularly moved by the effect that such experiences had on their subsequent lives, and the many years some went without relating their experiences to anyone except their closest friends and family. A few suffered in silence for close to ten years, reaching the point of almost total collapse before finally seeking help. Some of their recollections, though graphic and disturbing, proved to be encapsulations of numerous recurring themes I wished to address. Thus, interview excerpts are reproduced at the beginning of several chapters to highlight the prominent issues faced by veterans with psychological injuries, and the challenges of bringing this history out into the open.

In choosing which interviews to utilize, and where to place them in my narrative, I was forced to make subjective determinations of their relevance to the dissertation’s main themes as well as the degree to which the interview spoke to historical discussions of trauma. While some interviewees gave lengthy and detailed expositions about, for example, unfair treatment by superior officers or comrades, or interesting philosophical reflections on Canadian society vis-à-vis the military, in some instances I was clearly seen more as a sympathetic ear than an historical

investigator – something that in itself speaks to many veterans’ desire just to find someone that will listen without judgement. Thus while some discussions were ostensibly (and unintentionally) therapeutic for the interviewee, and their testimony may prove useful for future research, after transcribing all interviews I found some inherently more direct and pertinent to the themes that this dissertation addresses, and utilized them more often as a result.

Interviewees’ recollections proved to be a microcosm of larger narratives, and demonstrate the human story behind the medical, cultural, and political controversies. Readers should be warned: their reflections can be strikingly blunt, and in some cases the straightforward language they employed to describe traumatic events is in itself disturbing. Although I offered total anonymity to every interviewee, none wished it. Several instead expressed the hope that their uncensored and public story would prove helpful to other veterans afraid to come forward about their mental difficulties. Their testimonies represent a unique moment in Canadian history when soldiers and veterans are willing to publicly speak about their personal battles with trauma and with a military culture that emphasizes resiliency and toughness while shunning weakness. Prior to the 2000s, conducting this project would have been next to impossible, since groups such as OSISS did not exist, and given the closed nature of military culture, particularly in the 1990s, it is highly unlikely anyone would have been willing to relate their experiences to an “outsider.” A few interviewees confirmed this conjecture’s validity, and one told me I was lucky to find “the softest spot to push.”⁷² It remains to be seen whether or not this window will remain open to future researchers.

Listening to post-Cold War Canadian veterans’ difficult emotional journeys reveals a historical line that runs backward through time, to the similar experiences of their counterparts who served during earlier conflicts and operations. Although much has changed in Canadian

⁷² Godin, Andrew. Interview by author. Telephone. Toronto, July 20, 2014.

society and the Western world since 1914, traumatized veterans of the twenty-first century encounter many of the same dilemmas and are subject to many of the same socio-economic and cultural challenges as those who returned from the First and Second World War. Veterans' stories represent a direct link to the past and highlight the importance of viewing their experiences not just as individual struggles, but also as the metaphorical struggles of the nation. Although previous authors and documentarians have utilized interviews with veterans, and some have even highlighted trauma, this dissertation expands on that approach by making veterans' recollections the pivot point around which its historical discussion of trauma revolves. This dissertation "listens" to veterans and uses their thoughts as a way to reflect on how trauma is socially and philosophically *experienced*; essentially how trauma affects both one's social life and worldview, rather than how it is diagnosed and viewed in medical terms. As one interviewee poignantly stated, despite physicians' best efforts, trauma sufferers do not live in their doctor's office. By listening to individual and cultural experiences of trauma historians can add to a growing understanding of PTSD and its antecedents as both medical entities *and* profound, shattering social experiences. Canadian veterans are finally willing to speak candidly about the effects of war on both the psyche and soul, and it is our duty to listen.

CHAPTER 1: A SHOCKING INTRODUCTION TO TRAUMA

There is a legitimate nervousness, named “shell shock.” The real cases of this condition, when they are extreme, are sad to see. An officer or Tommy, who has previously been an excellent soldier, suddenly develops “nerves” to such an extent as to be uncontrollable. He trembles violently, his heart may be disorderly in rhythm, he has a terrified air, the slightest noise makes him jump and even occasionally run at top speed to a supposed place of safety. He is the personification of terror, at times crying out or weeping like a child.¹

A man that’s not afeard o’ thim shells has more courage than sinse.²

Writing in the late twentieth century, historian of military psychiatry Hans Binneveld opined that, “One can no longer imagine a battlefield without psychiatrists and psychologists.”³ Retrospectively, Binneveld’s assessment of the now inseparable link between the mental health profession and the military was somewhat prescient. The final decades of the twentieth century, in particular the 1980s and 1990s, saw the growth of a “culture of trauma” that made PTSD – a disorder defined by the American Psychiatric Association in 1980 – a hotly debated topic in military circles, medical journals, and newspapers across the Anglo-American world.⁴ In Western nations particularly, PTSD became a considerable concern for military leaders, as well as for the civilian governments they reported to. But such was not always the case. Throughout the twentieth century, psychological trauma oscillated between being a prominent subject and at other times a somewhat forgotten hobby of medical researchers. It was major conflicts like the two World Wars and Vietnam that were the key catalysts which continuously brought trauma back into the public eye.⁵ The conceptualization and dissemination of knowledge about trauma and combat-related psychological injuries were largely forged and re-ignited by the fires of war and, in the case of peacekeeping nations like Canada, “military operations other than war.”

¹ From the war memoir of Captain R.J. Manion, Canadian Army Medical Corps. See R.J. Manion, *A Surgeon in Arms* (New York: D. Appleton and Company, 1918), 163.

² Quoted *ibid*, 162.

³ Binneveld, *From Shell Shock to Combat Stress*, 1.

⁴ Shephard, *A War of Nerves*, 385.

⁵ *Ibid.*, *passim*.

Historians have discovered documented links between combat and intense psychological duress as far back as the seventeenth century, and the mental effects of battle on combatants were recognized even during Biblical times.⁶ Commenting on the timelessness of war's effect on the human psyche, military historian Richard Gabriel affirmed that, "If it were possible to transport a military psychiatrist back to the times of the Roman and Greek armies, there is little he would find in dealing with combat shock with which he was not already familiar."⁷ Nevertheless, despite ancient peoples' familiarity with war's stresses, it was only quite recently, along with the rise of professionalized medicine and modern technology, that psychological trauma was systematically studied. In their edited collection on the history of trauma, historians Mark Micale and Paul Lerner argued that in the period from 1870 to 1930 psychological trauma "acquired the status of a disease entity with a technical terminology, theories of causation, a classification, and therapeutic systems as well as medico-legal standing and governmental recognition."⁸ Trauma's newly acquired status derived in part from the fact that modernity brought with it unprecedented assaults on both the body and mind, but crucially, it also corresponded with organized medicine's first systematic study of how those assaults affected the human psyche.⁹ The rise of psychiatry, neurology, psychology, and other allied disciplines coincided with, and was constitutive of, medical and cultural engagement with psychological trauma on a hitherto unprecedented scale.¹⁰

Medical theories about psychological trauma began with mid- and late-Victorian physicians' curiosity about the unique types of injuries that occurred when humans broke

⁶Copp and Humphries, *Combat Stress*, 1; Allan English, "Historical and Contemporary Interpretations of Combat Stress Reaction," in Copp and Humphries, 445.

⁷ Gabriel, *No More Heroes*, 6.

⁸ Micale and Lerner, "Trauma, Psychiatry, and History," 11.

⁹ Ibid.

¹⁰ Ibid.

centuries-old rates of velocity and spatial boundaries.¹¹ In the case of early railways, one of the quintessential inventions of the modern age, a significant number of accidents resulted in many individuals suffering from “Railway Spine,” “Railway Brain,” or “Traumatic Neurosis,” an amorphous set of diagnoses that often involved a delayed stress response to the original traumatic event - in this case, a railway accident.¹² In his 1866 publication *On Railway and Other Injuries of the Nervous System*, John Eric Erichsen, British surgeon and professor at University College Hospital in London, described seven cases of Railway Spine. Patients’ mental difficulties puzzled physicians, particularly since Erichsen’s original hypothesis was that a concussive force led to chronic inflammation of the spinal cord, producing a general disturbance of the nervous system. Mystifyingly, some patients appeared physically cured but their psychological difficulties persisted. Detailing the 1866 case of a “Mr. R.,” a patient seen fifteen months after the man’s accident, Erichsen’s notes stated that Mr. R. was “unable to transact any business since the injury. Is troubled with frightful dreams. Starts and wakes up in terror, not knowing where he is. Has become irritable, and can neither bear light nor noise.”¹³ Physicians were even more perplexed when it became clear that in many cases no damage had been done to the patient’s spinal cord, thus rendering Erichsen’s organic explanation untenable.¹⁴ By the 1870s a number of physicians interested in psychological medicine and the puzzling nature of cases like Mr. R.’s began discussing the concept of psychological trauma, thus applying the concept of “trauma” to what had previously been utilized for strictly physical injuries.¹⁵ During

¹¹ Ibid., 10.

¹² Copp and Humphries, *Combat Stress*, 6-7.

¹³ John Eric Erichsen, *On Railway and Other Injuries of the Nervous System* (Philadelphia: Henry C. Lea, 1867 [1866]), 46-47.

¹⁴ Jones and Wessely, *Shell Shock to PTSD*, 14.

¹⁵ Micale and Lerner, “Trauma, Psychiatry, and History,” 9; Much of the controversy during the nineteenth century revolved around the fact that physicians, many coming from the somatic (physical) school of thinking, could not find significant physical injuries on their patient (or on their brain post-mortem), yet the patient still seemed affected

the 1880s Erichsen's organic explanation was challenged by other physicians, such as surgeon Herbert Page, who argued that intense fright alone could account for patients' symptoms and "traumatic hysteria."¹⁶

The debate over psychological trauma and its effects occurred on both sides of the Atlantic. In an early Canadian example, during an 1898 meeting of the Association of Railway Surgeons in Toronto, Mr. B.B. Osler, a solicitor, former prosecuting counsel against Louis Riel, and brother of Sir William Osler, spoke to a group of Canadian and American physicians about "'railway spine' or traumatic hysteria, which causes so much trouble to railway surgeons and to lawyers."¹⁷ Osler stated, like numerous future investigators, that, "The subjective nature of the symptoms made the subject very difficult," and that "doctors rarely agreed" when assessing railway spine cases.¹⁸ Thus, the railway accident and its mental effects became an important and formative aspect of the history of trauma, being the first time that such phenomena were systematically researched and discussed in medical circles.¹⁹ Railway spine created a new awareness of the ability of traumatic experiences to provoke a series of physical and psychological symptoms; it also supported beliefs that modern life brought with it traumas of a previously unseen nature.²⁰ Railway accidents metaphorically represented the rapid, uncontrollable, and sometimes shattering impact of modern technology on the human mind.²¹ As a medical *cause célèbre* during the late nineteenth century, railway spine laid the groundwork for

by the event. That dilemma, among other things, viz. the rise of psychology, led to exploration by some into the psychological realm.

¹⁶ Jones and Wessely, *Shell Shock to PTSD*, 14.

¹⁷ *The Globe* (Toronto), 7 July 1898; B.B. Osler was for a time the most famous trial lawyer in Canada. He died of heart disease a few years after this address, in February 1901. For a brief biography of his life see his obituary in *The Globe*, 6 February 1901; Erichsen, for his part, rejected any association between railway spine and traumatic hysteria. See Jones and Wessely, *Shell Shock to PTSD*, 14.

¹⁸ Jones and Wessely, *Shell Shock to PTSD*, 14.

¹⁹ Ralph Harrington, "The Railway Accident: Trains, Trauma, and Technological Crises in Nineteenth-Century Britain," in Micale and Lerner, *Traumatic Pasts*, 31-32.

²⁰ Eric Caplan, "Trains and Trauma in the American Gilded Age," in Micale and Lerner, 57-58.

²¹ Harrington, "The Railway Accident," 55-56.

future trauma debates. Thus, when physicians encountered “shell shock” during the First World War, they understood that despite pretensions of modern progress, human beings were still inherently fragile and helpless against technology’s darker, destructive side.

Over the Top

Although railway spine brought trauma under the lens of modern medicine, it was “shell shock” during the First World War that propelled psychological trauma into the spotlight and attracted attention from physicians, soldiers, civilians, and governments. The nature and scale of weaponry, the manner in which it was utilized, and the generally appalling conditions during the First World War affected men’s minds in diverse ways. Several months after the outbreak of war in December 1914, the War Office in London received reports that an alarming number of soldiers from the British Expeditionary Force were being evacuated with “nervous and mental shock.”²² According to those reports, 3-4% of all ranks were being returned to Britain due to “nerves” and other forms of mental breakdown.²³ Given the vicissitudes of what became a long and hard-fought war, every soldier counted, and as such, the British were quick to try and contain the problem. By early 1915 Dr. Charles Myers, a Cambridge University psychologist and MD, arrived in France as a “Specialist in Nervous Shock,” his goal to discover how to treat the numerous men ostensibly suffering from the shattering impact of enemy shells.²⁴

Historian Ben Shephard argued that shell shock was, “an early example of a common modern phenomenon: a medical debate, hedged with scientific qualifications, taken up by public opinion and the media in an oversimplified way.” He continued, “The early medical model of shell-shock, dominated by the image of the shell itself – a violent, concussive *deus ex machina*,

²² Shephard, *A War of Nerves*, 21.

²³ Ibid.

²⁴ Ibid; It was the French who first described shell shock in late 1914.

which arrived from out of the heavens and left the soldier a shattered, gibbering wreck, his nerves destroyed and his special senses, like eyesight and hearing, impaired – imbedded itself, in a crude and oversimplified way, in the public imagination.”²⁵ Much like how stress and PTSD in the late twentieth century became identified with Vietnam jungle warfare, shell shock, presumed to originate from exposure to the concussive power of artillery barrages, became the iconic medical disorder of the First World War – an image still attached to the public consciousness across much of the world today.²⁶

Public sympathy toward shell shock in Britain and the rest of the Anglo-American world stemmed from frequent newspaper reporting, which by 1917 created the impression that shell shock was a normal and frequent consequence of war.²⁷ A 1918 *Globe* article about a Boston Smith College course for women to assist in treating shell shock sufferers, which exaggeratedly proclaimed that in Canada “90 per cent of returned soldiers suffer from some nervous disorder,” certainly did much to contribute to such an impression.²⁸ Nevertheless, sympathy and popular understandings went against military necessities and a military culture that did not tolerate weakness.²⁹ Army attitudes to mental disorder were interwoven with traditional masculine

²⁵ Ibid., 28.

²⁶ Binneveld, *From Shell Shock to Combat Stress*, 83.

²⁷ Copp and Humphries, *Combat Stress*, 14.

²⁸ *The Globe*, 3 October 1918.

²⁹ The most obvious, and controversial, manifestation of that culture was the execution of 307 men for desertion, cowardice, and other offences from 1914 to 1918. Many of those men are now believed to have suffered from shell shock or what would today be termed combat stress or PTSD. In Britain in 1993 a movement was begun by a British MP to obtain retrospective pardons for them, but was denied by then British Prime Minister John Major, on the basis that to do so would be rewriting history, and that shell shock was known to medical men during the First World War; the implication being that if they were innocent and indeed shell-shocked, medical knowledge would have prevented their execution. In the Canadian context, in 2001 the 23 soldiers executed for desertion and cowardice during the war had their names added to the Book of Remembrance in the Memorial Chamber of the Peace Tower on Parliament Hill. Such a move allowed the government to avoid being accused of rewriting history but still recognize that the men in question died while serving their country. In 2006, Britain eventually pardoned the 307 executed men (including the 23 Canadians). The decision was not without controversy though. Cliff Chadderton, chairman of Canada’s National Council of Veterans Associations argued that despite the executions seeming brutal by twenty-first century standards, “I think it’s wrong to pardon them, because they deserved what they got.” See Shephard, *A War of Nerves*, 67, where he uses archival evidence to refute John Major’s stance on physicians and shell shock; See also *The Globe and Mail*, 12 December 2001 and 16 August 2006 for coverage of this issue.

principles of honour, stoicism, self-control, and camaraderie.³⁰ Mental disorder was linked with weakness, effeminacy, and cowardice, and viewed as something “treatable” by disciplinary actions.³¹ Plainly put, it was only the abnormal man who was frightened or repulsed by the sights, sounds, and actions of battle.³² At the same time as the British military applied a simplistic “sick, well, wounded, or mad” model to soldiers’ health, military physicians faced the reality that the war produced large numbers of soldiers who broke down in battle with manifestations that slipped between the cracks of crude categories.³³ Unable to fully grasp or classify the numerous types of troubled soldiers they encountered, doctors at the front sometimes resorted to simplistic or idiosyncratic labels such as “Mental” or “Insane,” and even unusual terms like “GOK,” an initialism for “God Only Knows.”³⁴

Military physicians were in the unenviable position of having to “invert normal civilian practice and go to great lengths to deny that a soldier was sick,” thereby preventing military “wastage,” while still tenuously clinging to their other duty – treating the sick.³⁵ Canadian surgeon Robert James Manion, a Medical Officer, Military Cross winner at Vimy Ridge, and later Conservative MP, provided an in-depth view of life in the trenches in his 1918 memoir *A Surgeon in Arms*. He recalled frequently being visited by officers before battle and informed of individual soldiers’ “cold feet,” to prevent them from obtaining a medical reprieve under the pretense of illness.³⁶ Since many early cases of shell shock were evacuated back to England, with most never returning to the battlefield, the military became concerned about the degree to which

³⁰ Shephard, *A War of Nerves*, 25.

³¹ Ibid; In the rare cases that a soldier’s mental state was so chronically deteriorated, or he showed obvious signs of being mentally unfit to serve, he was sent to an asylum.

³² Joanna Bourke, “Effeminacy, Ethnicity and the End of Trauma: The Sufferings of ‘Shell-Shocked’ Men in Great Britain and Ireland, 1914-39,” *Journal of Contemporary History* 35, no. 1 (2000): 59.

³³ Shephard, *A War of Nerves*, 25.

³⁴ Ibid., 29.

³⁵ Ibid., 26.

³⁶ Manion, *A Surgeon in Arms*, 19.

knowledge of the term shell shock and its vagueness allowed malingerers – those feigning illness to avoid duty – to seek an honourable exit.³⁷

Based on his experiences as a Medical Officer during the First World War, British physician Lord Moran stated in his 1945 account of war's psychological effects that, "When the name shell-shock was coined the number of men leaving the trenches with no bodily wound leapt up. The pressure of opinion in the battalion – the idea stronger than fear – was eased by giving fear a respectable name ... The resolve to stay with the battalion had been weakened, the conscience was relaxed, the path out of danger was made easy."³⁸ Put simply, shell shock's amorphous symptoms and confusion about its causes allowed fearful soldiers to escape along with the genuinely ill. Colin Russel, a Canadian neurologist and later head of the neuropsychiatric ward of the Granville Canadian Special Hospital, Ramsgate, in England, summed up the situation in a 1919 article in the *Journal of Abnormal Psychology*: "Owing chiefly to the fact that these [shell shock and other] conditions were not fully recognized in the beginning, many cases were evacuated to England which would not otherwise have been, and the depletion of manpower in the front line from this cause became a very serious item."³⁹ In the summer of 1916 during the Battle of the Somme, one of the bloodiest battles in history, shell shock grew to "epidemic proportions."⁴⁰ As experts came into contact with a greater number of cases, it became clear that "shell shock" served far more as an evocative symbol of modern

³⁷ Ibid., 31.

³⁸ Lord Moran, *The Anatomy of Courage: The Classic WWI Account of the Psychological Effects of War* (New York: Carroll and Graf Publishers, 2007 [1945]), 184.

³⁹ Colin Russel, "The Management of Psycho-Neuroses in the Canadian Army," in Copp and Humphries, *Combat Stress*, 22; During the war Myers also agreed with this view, stating that he had seen far too many men who claimed they were suffering from shell shock with nothing visibly (or otherwise) wrong with them. See Shephard, *A War of Nerves*, 29; A note about terminology: neuropsychiatry often referred to neurology and psychiatry, since it dealt with diseases attributable to the mind and nervous system as it was then understood. This changed later when psychiatry and neurology split from one another into distinct disciplines with uncommon training, though neuropsychiatry has again become a growing branch of psychiatry in the twenty-first century.

⁴⁰ Copp and Humphries, *Combat Stress*, 11; According to archival material utilized by Shephard, during the first few weeks of the Battle of the Somme the British alone evacuated "several thousand" due to "nervous disorders." See Shephard, *A War of Nerves*, 41.

warfare, and in some instances fear, than as an accurate description of what troubled many soldiers.

By June 1916, the first authoritative study of shell shock was published by Harold Wiltshire, an experienced London physician who saw over 150 cases and compared notes with military doctors at the front. He argued that, in most cases patients showed little or no physical damage. The problem's root, he believed, was psychological.⁴¹ He pointed to a "psychic shock" as the cause of many men's symptoms, providing one example of a soldier who was traumatized after clearing away the remains of a group of men killed by shellfire.⁴² Somewhat presciently, Wiltshire also noted the ability of the mind to repress sights and emotions it was unable to fathom, an ability discussed at great length after the war and throughout the rest of the century in relation to trauma.⁴³ Charles Myers, who helped popularize the term "shell shock" in 1915 in the *Lancet*, now realized the reality of war trauma was far more complex, and by 1916 with other experts like Wiltshire attempted to re-label shell shock and its manifestations "war neuroses" or "functional nervous disorders."⁴⁴ Their rebranding reflected a shifting medical consensus about the perceived psychological cause of many shell shock cases and an attempt to preserve medical authority over such matters. Moreover, at the command level, it highlighted medical officers' and other experts' partnership with military authorities to keep shell shock out of the hands, or more accurately put, the minds, of individual soldiers. Replacing shell shock with the more esoteric terms "neuroses" and "nervous disorders" was intended to prevent soldiers from arriving at their own diagnosis and ensure that stigmas about mental disorder kept them in line.

⁴¹ Ibid., 31.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Ibid., 32.

The Canadian Expeditionary Force (CEF), which sent 600,000 members overseas during the First World War, also had many soldiers diagnosed with war-related psychological injuries – estimates range between 9,600 and 15,000.⁴⁵ Faced with such numbers the Canadian Army established two neurological hospitals at Granville and Buxton in England in 1915-16.⁴⁶ Historian Tom Brown demonstrated that, similar to the British army, shell shock became a battleground on which Canadian physicians vied with each other as well as the exigencies of war and military culture. Psychiatry was a “divided profession” on the eve of war. Somaticists, who believed that mental and nervous disorders were the product of physical lesions, contended with followers of Freud and other prominent neurologists, psychologists, and psychiatrists, who argued such disorders were not brain diseases, but disorders of the mind.⁴⁷ Robert Manion, cited above, believed shell shock’s root cause was “the subjection of the nervous system to a strain which it is unable to withstand, making it collapse instead of resiliently rebounding.”⁴⁸ Such a collapse could be brought about by “the effects of severe shelling; by being buried by an explosion of shell or mine; or by the killing beside the sufferer of a companion.”⁴⁹ Regardless of their theoretical stance, though, Canadian Army physicians were not free from contemporary value judgements about cowardly behaviour, nor their prime directive – to return as many soldiers as possible to battle.

⁴⁵ The first figure comes from Copp and Humphries’ *Combat Stress*, 8, the latter figure from Humphries 2010 article “War’s Long Shadow,” 503.

⁴⁶ Copp and Humphries, *Combat Stress*, 10; The establishment of “neurological” hospitals itself for those injuries and genuine physical injuries to the head was in itself demonstrative of prevailing beliefs about the organic cause of shell shock and other psychological injuries.

⁴⁷ Tom Brown, “Shell Shock in the Canadian Expeditionary Force,” 310-311; For an excellent account of developments in the somatic and psychological realms see Allan Young, *The Harmony of Illusions*, 13-42., esp. 20-21; and Mark Micale, *Hysterical Men*, chs. 3,4,5.

⁴⁸ Manion, *A Surgeon in Arms*, 164.

⁴⁹ Ibid; It is interesting to note that while Manion seemed to subscribe to a physical explanation (a collapse of the nervous system) for shell shock, his latter example of seeing a comrade killed, during which time the man did not necessarily sustain physical injury, implied a purely psychological sapping of the nerves. In that regard Manion seems to have taken the middle path rather than subscribing to a strictly physical or mental theory.

Many doctors did not consider shell shock a legitimate war injury. Instead, they believed the shell-shocked soldier “suffered from a lack of moral courage, a failure of the will, [and] a loss of self-control.”⁵⁰ Manion, a rare exception to the rule, deemed shell shock “a legitimate nervousness,” and something which in the extreme case was “pitiable to observe.”⁵¹ But when assessing a soldier reporting mental or physical injuries, the medical officer’s loyalty was first and foremost to the Army. Although the individual was of paramount concern to the physician in peacetime, in war it was necessary to “look at disease and physical non-effectiveness from a collective point of view.”⁵² It was for this reason that on one occasion while reviewing sick troops Manion overheard a disgruntled soldier mutter “one never gets a fair deal from a military doctor.”⁵³ Distinguished Canadian physician Sir Andrew Macphail, early editor of the *Canadian Medical Association Journal* and himself a Vimy Ridge veteran, believed shell shock was at its core a display of “childishness and femininity.”⁵⁴ Macphail’s belief, shared amongst most medical officers and civilian physicians, demonstrated the link contemporary doctors made between the hysteria-like symptoms of shell shock and hysteria’s long history as a disorder deemed predominantly feminine.⁵⁵ For the soldier who had “his wind up” or simply wanted out, though, a shell shock diagnosis provided a legitimate way to exit the conflict. Thus shell shock constituted a serious issue for military authorities and governments, both ultimately concerned

⁵⁰ Brown, “Shell Shock in the Canadian Expeditionary Force,” 315.

⁵¹ Manion, *A Surgeon in Arms*, 163-164.

⁵² Quoted in Joanna Bourke, “Effeminacy, Ethnicity and the End of Trauma,” 62.

⁵³ Manion, *A Surgeon in Arms*, 37.

⁵⁴ Quoted in Brown, “Shell Shock in the Canadian Expeditionary Force,” 315.

⁵⁵ Desmond Morton, *Fight or Pay: Soldiers’ Families in the Great War* (Toronto: UBC Press, 2004), 151; Physicians in the Great War were also initially influenced by French research into “traumatic hysteria,” especially the work of Jean-Martin Charcot. See Micale, *Hysterical Men*, 5-7, 139; For more on hysteria see also Micale, “On the ‘Disappearance’ of Hysteria: A Study in the Clinical Deconstruction of a Diagnosis,” *Isis* 84, no. 3 (1993): passim; Elaine Showalter, *The Female Malady*, passim, esp. 133-134.

with victory. Lord Moran described the weariness and fear that pervaded the ranks in 1917 as “no longer a private anxiety, it had become a public menace.”⁵⁶

By mid-1917, with the war’s outcome still in doubt, Commander of the British Army Sir Douglas Haig forbade use of the term “shell shock” verbally, in any reports, or on medical documents, except in cases classified by the Officer Commanding the Special Hospital. In place of “shell shock” doctors were to use “Not Yet Diagnosed – Nervous (NYDN),” a term that prevented soldiers from self-diagnosis and, at least officially, removed shell shock as a recognized war wound.⁵⁷ Haig’s order reflected not only concerns about manpower, but also the reality that, as neurologist Colin Russel reported, many soldiers were diagnosed with shell shock despite never actually seeing the battlefield.⁵⁸ Although physicians attempted to help officers “sort out the shirkers from the heroes” and provided medical backing to the military’s stance on shell shock, it was evident by war’s end that psychological medicine could neither unequivocally explain and categorize psychological trauma nor prevent some – either physicians or patients – from applying “shell shock” as they saw fit.⁵⁹ Once the proverbial genie was out of the bottle it proved difficult to contain. In spite of authorities’ attempts the term remained in circulation by both physicians and soldiers throughout the rest of the war, becoming in one sense a medical condition, and in another sense a metaphor for the physical, spiritual, and mental traumas of the Great War.⁶⁰ Shell shock’s resonance also supported Paul Fussell’s appraisal of the War’s ability to stimulate a shift in consciousness.⁶¹ In a similar manner to how soldier-authors during the Great War utilized literary traditions to rationalize the War’s horrors, shell shock symbolized a

⁵⁶ Lord Moran, *The Anatomy of Courage*, 185.

⁵⁷ Copp and Humphries, *Combat Stress*, 14.

⁵⁸ *Ibid.*, 13.

⁵⁹ *Ibid.*

⁶⁰ Shephard, *A War of Nerves*, 32; Jay Winter, “Shell-shock and the Cultural History of the Great War,” *Journal of Contemporary History* 35, no. 1 (2000): 7.

⁶¹ Fussell, *The Great War and Modern Memory*, *passim*.

physical, mental, and societal attempt to explain the Great War's effect on the collective psyche. Essentially, shell shock became a medical ailment for some and an explanatory device for others.

Shocking Legacies

Shell shock's prominent appearance during the First World War was a turning point in the history of psychological trauma. Abram Kardiner, an American psychoanalyst who saw over 1000 patients with war-related "neurotic disturbances" in the 1920s, wrote in his seminal 1941 work *The Traumatic Neuroses of War*: "The neuroses incidental to the great war made the world neurosis-minded. They were studied with more care than at any time previously, and the literature is encyclopedic."⁶² The most salient issues: the need to define "war neuroses;" sorting out the legitimately injured from the "effeminate" and malingerers, not just for battle but also for pension purposes; reconciling military needs with the reality that modern warfare was inherently traumatic for participants; and the role of the press in bringing psychological injuries to public consciousness, remained common themes throughout the twentieth century.

Regardless of physicians' ostensible success or failure during the war, both psychiatry and psychology were visibly strengthened by their wartime use. In Canada, as elsewhere, psychiatry was enhanced by its newfound need for services outside of the asylum, its traditionally sole locus of practice.⁶³ The discipline emerged from the First World War with "a new-found sense of professional identity and self-worth, its status and prestige greatly enhanced in the public mind."⁶⁴ It was, Tom Brown noted, not coincidental that the Canadian National Committee for Mental Hygiene (CNCMH), the forerunner of the Canadian Mental Health

⁶² Abram Kardiner, *The Traumatic Neuroses of War* (New York: Paul B. Hoeber, 1941), v; Kardiner was one of the first to make explicit connections between peace and wartime trauma (traumatic neurosis), stating that the peacetime traumatic neuroses were "the same in structure as those precipitated in war." See *ibid.*

⁶³ Tom Brown, "Shell Shock in the Canadian Expeditionary Force," 322.

⁶⁴ *Ibid.*, 323.

Association, was formed in 1918.⁶⁵ After the Great War psychiatrists played a leading role in deciding many of the issues noted above, namely defining war neuroses, aiding governments in pension decisions, and modifying programs for mentally ill veterans. Leaders in the fledgling Canadian mental health field took steps to ensure their position was secured and enlarged. One of the first aims listed for the newly formed CNCMH was, “War Work (a) Psychiatric examination of recruits [and] (b) Adequate care of returned soldiers suffering from mental disabilities.”⁶⁶ A February 1918 article on the CNCMH’s formation in the home of a Mrs. Dunlap highlighted the Committee’s ambitious aims: “[the study of] problems of mental health, nervous and mental disorders, mental deficiency, epilepsy, inebriety, and the mental factors involved in crime, prostitution, pauperism, immigration and the like.”⁶⁷ Among the many luminaries present at the formation were: Dr. C.K. Clarke, Dean of Medicine and Professor of Psychiatry at the University of Toronto; Clifford Beers, founder of the American National Committee for Mental Hygiene; Dr. E.A. Bott, later head of the Psychology Department at the University of Toronto and specialist in aviation psychology for the Royal Canadian Air Force in World War Two; and the aforementioned Great War neurologist and shell shock expert Colonel Colin Russel.⁶⁸ Top officials in the postwar mental health professions had a strong connection to the military. For many it proved to be a training ground for testing out new ideas and gaining credibility as experts on a wide range of non-military issues.

⁶⁵ Ibid.

⁶⁶ Canadian Mental Health Association. “History of CMHA.” <http://www.cmha.ca/about-cmha/history-of-cmha/#.VNJ8CS5hwnM> (accessed January 14, 2014).

⁶⁷ *The Globe*, 27 February 1918.

⁶⁸ Ibid; A testament to the prominence and influence of the CNCMH founders was its Board of Directors. The early board included: Lord Shaughnessy, President of the CPR; Richard B. Angus, Montreal financier and philanthropist; Dr. C.F. Martin, Professor of Medicine, McGill University; Sir Vincent Meredith, President, Bank of Montreal; and F.W. Molson, President of Molson’s Brewery. Each board member pledged \$1000 a year for three years, the not so insignificant sum of \$13,244.68 per annum in 2014 terms. Lieutenant-Colonel Sir Charles Vincent Massey, future Governor General of Canada, was also on the Executive Committee.

While the mental health professions benefitted from the war's effect in stimulating academic interest in the mind, the frontline soldier's experience with shell shock became an individual and collective trauma planted deeply enough that forgetting the war was often impossible. For those lucky enough to escape death or physical injury there were the lingering effects of witnessing carnage and destruction on a hitherto unprecedented scale. The work of shell-shocked British poets Wilfred Owen and Siegfried Sassoon, and most famously in the Canadian context John McCrae's "In Flanders Fields," were testaments to a war that haunted many of its participants for the rest of their days.⁶⁹ Even civilians were fascinated by shell shock and attempted to distill its essence in print, a trend exemplified in the interwar period by the character Septimus Warren Smith in Virginia Woolf's 1925 novel *Mrs. Dalloway*. In the book, Smith, a First World War veteran suffering from shell shock, commits suicide after experiencing postwar hallucinations and receiving the news he is to be involuntarily committed to an asylum.⁷⁰ Though fictional, Smith's story was representative of the ghosts that haunted numerous veterans upon their return home. Cultural depictions of veterans' lingering trauma played an important role in helping postwar societies come to terms with the Great War's immense destruction and sense of loss. Crucially, they also underpinned political discussions about the veteran's role in postwar society. Lastly, books like *Mrs Dalloway* highlighted that for many men the war's end only signified the beginning of the "second battle" – reintegration to civilian

⁶⁹ Both Owen and McCrae did not survive the war, with the former being killed in action one week before the 1918 Armistice and the latter dying of pneumonia early that year.

⁷⁰ Virginia Woolf, *Mrs. Dalloway* (London: Harcourt, 2001 [1925]). The works of British novelist Pat Barker, whose *Regeneration Trilogy* of the 1990s focused on the effects of trauma, were a testament to the enduring nature of the First World War and fascination with its traumatic character amongst both historians and novelists. Her first work in the trilogy, *Regeneration*, which portrayed a fictionalized encounter of Sassoon, Owen, and pioneering psychologist W.H.R. Rivers, was quite popular and was made into a 1997 film of the same name.

society and the fight for financial compensation. For those whose minds were temporarily or permanently affected by the war, that battle was made much more difficult.

The Great War produced thousands of veterans who returned physically and mentally wounded, and the question of what constituted a legitimate injury was a thorny issue after the 1918 Armistice. In Canada, as in other combatant nations, the return of wounded soldiers greatly strained the already fragile socio-economic order. Unlike in previous wars, such as the Second Anglo-Boer War, when disease far outstripped the number of soldiers killed in battle, the First World War was unique because the majority of sick and wounded troops returned home alive.⁷¹ The sheer scale of returning men compounded a problem that existed because, “Pensions, bounty, [and] kindred issues hardly rippled the surface before 1914.”⁷² Nevertheless, as early as 1915, Canadian officials outlined a program for retraining and rehabilitating soldiers, first through the Military Hospitals Commission (MHC) and by October 1915 the Military Hospitals and Convalescent Homes Commission (MHCHC).⁷³ The Commission provided medical care, vocational training, and occupational therapy, with the goal being veterans’ future independence and employability; a purported win-win for both parties. Despite a large number who benefited from the program, in 1919, the year the Pension Act received royal assent, Canada had 42,932 disability pensioners, and by 1939 their number had grown to 80,103. Pensions were a great

⁷¹ Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadians Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987), 9; Morton and Wright’s account provides an excellent traversal through the labyrinthine and confusing political and legal wrangling of the post-1918 period. It is a testament to their work and the subject’s difficulty that no other authors have attempted a grand narrative of this period in Canada since its publication. It is important to note that as Morton and Wright showed, pensions were not a new topic in Canada, but rather the *scale* of the problem was unprecedented. Additionally, it must also be noted that it was the Russo-Japanese War which first saw more soldiers killed in battle than by disease.

⁷² *Ibid.*, 13.

⁷³ *Ibid.*, 18.

financial strain on the federal government, and proved to be a controversial issue throughout the interwar period.⁷⁴

Canadian federal officials attempted to steer a path between Britain's perceived conservative approach towards veterans' pensions and the "pension evil" that followed the end of the Civil War in the United States just over fifty years prior. In the former case, Canadians visiting Britain before 1914 remembered veterans begging on street corners, while in the United States a more liberal approach to pensions had led to many abuses. So-called "deathbed marriages" and a proliferation of claims agents and pension attorneys looking to make their fortune through exploiting loopholes in the system, supposedly on behalf of their clients, meant that by 1914 one-fifth of U.S. federal spending was earmarked for veterans' pensions.⁷⁵ The Canadian government aimed to avoid both outcomes. The creation of the MHC and its future incarnations represented an eclectic approach that attempted to balance veterans' needs and the nation's obligation to them with a desire to save money wherever possible. Keeping pension costs down and ensuring the public treasury was protected meant taking a firm stance on the question of deserving and undeserving veterans. Unfortunately for numerous veterans, the ostensibly objective approach of pension officials and advising physicians was often coloured with contemporary moral judgements about masculinity and a prevailing middle-class doctrine of industry and adaptability. Canada was far from European battlefields, and though Canadians read about the horrors of trench warfare, many still viewed veterans unable to gain or keep employment as evidence of the traditional "fecklessness of soldiers."⁷⁶ Their attitude reflected

⁷⁴ Ibid., 234; The number of disability pensioners ranged between 15,335 in 1918 and 80,104 in 1939. That figure did not include dependents, a number that itself ranged between 10,488 and 20,015 from 1918 to 1939. It was a testament to the highly politicized nature of the pension debate and the strong advocacy by veterans associations, as well as the Depression's impact on jobs and veterans' ability to maintain economic means, that the Pension Act was amended *sixteen* times between 1919 and 1939.

⁷⁵ Ibid., xi.

⁷⁶ Morton, *Fight or Pay*, 162.

historical middle-class views of the traditional soldier: a working-class man, usually of criminal temperament, who in Prime Minister Sir John A. Macdonald's opinion was only skilled at hunting, drinking, and chasing women.⁷⁷

During the interwar period, when an ostensibly injured veteran appeared before a pension board the biggest single concern for officials was "attributability" – whether or not the injury was attributable to war service.⁷⁸ While on the surface a seemingly easy question, the open-ended interpretation of attributability led down many paths. In their 1987 work *Winning the Second Battle* historians Desmond Morton and Glenn Wright succinctly stated the issue's intricacies: "Disability might be an objective medical question; how far the disability was 'attributable' to service was a matter of almost metaphysical complexity."⁷⁹ Visibly disabled soldiers who lost a limb or suffered gunshot wounds could be quickly assessed and classified on a pension scale, but many injuries were not as easily pigeonholed.⁸⁰ As but one example Morton and Wright cited soldiers who contracted syphilis overseas. Pension officials perhaps rightly questioned whether or not soldiers could attribute venereal disease to war service.⁸¹

Throughout and after the Great War, even more than physical injuries, mental illness constituted a troublesome category for the Commission and its later forms, the Department of Soldiers' Civil Reestablishment (DSCR) and the Department of Pensions and National Health (DPNH). That trouble was partially due to returning soldiers who suffered war-related trauma and partially to lax enlistment standards that allowed "obviously insane" recruits to sign up for

⁷⁷ Allan English, *Understanding Military Culture: A Canadian Perspective* (Montreal & Kingston: McGill-Queen's University Press, 2004), 87.

⁷⁸ Morton and Wright, *Winning the Second Battle*, 56; For an excellent and concise explanation of the Board of Pension Commissioners pension scale, see Peter Neary, *On to Civvy Street: Canada's Rehabilitation Program for Veterans of the Second World War* (Montreal & Kingston: McGill-Queen's University Press, 2011), 11.

⁷⁹ Morton and Wright, *Winning the Second Battle*, 56.

⁸⁰ Copp and Humphries, *Combat Stress*, 83.

⁸¹ Morton and Wright, *Winning the Second Battle*, 56.

the CEF.⁸² While the provincial and federal bureaucracies argued over the cost and responsibility of sending them to an asylum, the public and veterans' associations objected to such measures because they believed veterans driven to chronic mental illness by war deserved more than overcrowded, neglectful, and stigmatizing mental institutions.⁸³ In the case of shell-shocked soldiers, anger over sending them to mix with incurable civilian patients, many of whom were at that time the senile elderly and chronic schizophrenics, eventually convinced the Commission to utilize a former mental hospital at Cobourg, Ontario as a centre for shell shock sufferers. The irony of housing veterans in a former civilian asylum, and the treatment methods employed, many of which resembled traditional asylum methods, was lost on Commission officials.⁸⁴ At Cobourg the treatment regimen ranged from benign therapy like sports to more intense measures such as electroshock, the latter often utilized to help "will" the veteran back to good health.⁸⁵ Public sympathy and advocacy by groups like the Great War Veterans Association, one of the forerunners of the Royal Canadian Legion, helped to find places for the severely affected, but the compensation issue was much more complex.

Military and cultural historians Terry Copp and Mark Humphries succinctly summed up the Canadian interwar pension situation for shell shock sufferers, indicating that the pension issue "made sure that the debate over the aetiology [cause] of shell shock remained at the front

⁸² Ibid., 27; In February 1918 the Commission became the Department of Soldiers' Civil Reestablishment, which itself merged in 1928 with the Department of Health, becoming the Department of Pensions and National Health.

⁸³ Ibid; Asylums during this period were viewed by most as a last resort, since the conditions were believed to make an already bad (mental) situation worse. In medical historian Edward Shorter's estimation, "By World War I, asylums had become vast warehouses for the chronically insane and demented." The second chapter of his *History of Psychiatry* provides an excellent overview of the asylum era in the west. See Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Toronto: John Wiley & Sons, 1997), 33-68; Historians John Weaver and David Wright pointed out that families' and patriotic associations' attempts to keep soldiers out of asylums spoke to the enduring stigma attached to the mentally ill. See John Weaver and David Wright, "Shell Shock and the Politics of Asylum Committal in New Zealand, 1916-22," *Health and History* 7, no. 1 (2005): 36.

⁸⁴ Shorter, *A History of Psychiatry*, 65.

⁸⁵ Morton and Wright, *Winning the Second Battle*, 96; Cobourg was the only hospital in Canada solely dedicated to caring for traumatized soldiers. It had 425 beds and its mission was to cure shell shock sufferers and return them to civilian life. As noted by Copp and Humphries, the "cure" was more a matter of whether or not a soldier became self sufficient than any medical recovery. See Copp and Humphries, *Combat Stress*, 95.

and centre of the [medico-legal] discourse. After all, if shell shock was due to bursting shells or noxious gases, surely a soldier's disability was attributable to war. If it were due to some innate weakness of character or defect in biology, on the other hand, the state would be spared a significant burden."⁸⁶ Limited medical knowledge and a desire to control costs combined to ensure that physicians and pension officials fell back on hereditary and/or character flaws to deny "attributability."⁸⁷ They essentially explained shell shock victims' inability to engage in a productive postwar life as self-induced malingering.⁸⁸ Russel, the CEF's chief shell shock specialist cited earlier, believed shell-shocked soldiers willed themselves to sickness. In such cases, by providing pensions the government only encouraged their inappropriate behaviour and continued dependence on the state.⁸⁹ That strategy allowed officials to reduce pension costs and, in their minds, renew veterans' desire for gainful employment.⁹⁰ Numerous physicians viewed their encounter with shell-shocked men as a symbolic battle in which the former must be victorious.⁹¹ Essentially, "Whether doctors took them seriously or dismissed them as cowardly

⁸⁶ Copp and Humphries, *Combat Stress*, 83.

⁸⁷ David Healy, *The Creation of Psychopharmacology* (London: Harvard University Press, 2002), 28-29; The genetic/hereditarian view espoused that a person's constitution and character were largely inherited from previous generations, and if one were afflicted with a mental disorder physicians and psychologists most often looked to an individual's family history for the potential source. If a mentally ill relative was found in the family tree, this confirmed the perceived hereditary taint. The insidious and terrifying quality of this view was that many physicians in the late-nineteenth and early-twentieth century believed in the concept of "degeneration," a concept which affirmed that inherited mental illness worsened with time, potentially leading to the destruction of a family line and in theory, an entire population. For a concise overview of degeneration theories see Shorter, *A History of Psychiatry*, 93-99.

⁸⁸ Copp and Humphries, *Combat Stress*, 83.

⁸⁹ Morton and Wright, *Winning the Second Battle*, 75; This thinking was most clearly spelled out by Freud in his 1917 *Introductory Lectures on Psycho-Analysis*, where he elucidated the concept of secondary gain. Secondary gain referred to the patient's perceived social advantages gained by their illness; in the case of shell-shocked soldiers the most obvious being a pension, or in wartime the avoidance of duties or combat. Secondary gain comes from external motivations, while primary gain comes from internal motivations, such as in conversion disorder, when a person manifests physical symptoms without any discernible organic causes. The "gain" comes from the removal of anxiety that the symptom produces.

⁹⁰ This was not a uniquely Canadian stance. In Britain pension officials were likewise "obsessed" with proving that most mentally ill veterans were malingerers. See Joanna Bourke, "Effeminacy, Ethnicity and the End of Trauma," 63.

⁹¹ Copp, "From Neurasthenia to Post-Traumatic Stress Disorder," 151.

malingers, the consequences were virtually identical.”⁹² Physicians did acknowledge that some veterans were so severely affected they could never be employed or care for themselves again. For that category they recommended asylum committal. The remainder were left to convince pension officials their inability to reintegrate was a result of war trauma rather than their own innate, personal flaws.

At a societal level, pension seeking for wartime trauma was in and of itself viewed by many as a transgression of social norms, namely masculine codes that required men to be “aggressive, self-reliant, and un-emotional.”⁹³ Mark Humphries’ research with Canadian veterans’ pension documents showed that even soldiers whose diagnosis had verified them as “real men” in wartime were often refused state assistance in the postwar period.⁹⁴ The reason, beyond cold economic concerns, was that, crudely stated: “Real men did not break down, nor did they allow their emotions to interfere with their manly duty as breadwinners and providers.”⁹⁵ Constructed thus, the Board of Pension Commissioners, responsible for granting and reviewing pension claims, utilized ostensibly objective medical science to bolster beliefs that “shell shock,” “neurasthenia,” and other categories of psychological illness were the result of character defects, most often of a hereditary or dispositional nature.

The Board’s approach drew not just on medicine and psychology, but also longstanding lay perceptions and constructions of manliness. Educational historian Mark Moss’ 2001 work on the mid-nineteenth and early-twentieth century education of young boys in Ontario – a province that produced almost half of CEF volunteers – revealed that a host of secular organizations such as the YMCA, Boy Scouts, patriotic clubs, libraries, and schools instilled in young boys a belief

⁹² Morton and Wright, *Winning the Second Battle*, 75.

⁹³ Humphries, “War’s Long Shadow,” 503.

⁹⁴ *Ibid.*, 530.

⁹⁵ *Ibid.*

that the ultimate test of manliness was war.⁹⁶ In a society undergoing vast socio-economic changes war was “an antidote to the crisis of masculinity, the fear of being perceived as effeminate, the plague of luxury and materialism, [and] the changes brought about by industrialism and the feminization of society.”⁹⁷ Seen against this historical backdrop, doctors’ hesitancy about legitimizing war trauma was both an expression and reinforcement of societal norms. Put simply, to be unduly affected after the war’s end meant failure as a man. Physicians were ultimately concerned with perpetuating social norms, protecting the socio-economic order, and ensuring their continued place as experts in pension questions.⁹⁸ Their assessments were based more on professional interests and predominant middle-class beliefs than objective medical science.⁹⁹

One of the unfortunate results of government and medicine’s partnership in the interwar period was that, “thousands of legitimately traumatized veterans were left uncompensated by the state and were constructed as inferior, feminized men.”¹⁰⁰ While psychologically injured veterans’ losses were measurable in denied compensation, their difficulties were also less tangibly evident in a rejection and humiliation received at the hands of pension officials and physicians. Throughout the interwar period the number of veterans manifesting psychological problems increased, particularly as the Depression set in. Many were confined in public asylums across the country, leaving them suffering in silence amidst other mentally ill patients and forcing their families to contend with the socio-economic difficulties of losing a father, husband, brother, or son. The rest, haunted by war but uncompensated in peacetime, were granted “the

⁹⁶ Moss, *Manliness and Militarism*, 15.

⁹⁷ Ibid., 143; Those fears were based to some degree on an “increasingly visible and vociferous women’s movement [that] accentuated self-doubt.” See ibid., 110; Worries about societal decline and men’s effeminization were also thoroughly covered in a European context by Micale. See Mark Micale, *Hysterical Men*, passim.

⁹⁸ Humphries, “War’s Long Shadow,” 530.

⁹⁹ Copp and Humphries, *Combat Stress*, 91.

¹⁰⁰ Humphries, “War’s Long Shadow,” 503.

renewed privilege of fending for themselves in a business-like, profit-driven society.”¹⁰¹ When shell shock pensions *were* awarded – a rare occurrence – they were often only granted for six months to a year, rendering their recipient’s financial troubles ameliorated for only a brief duration.¹⁰² It must be acknowledged that for the vast majority of returned soldiers, life after 1918 resumed with old or new employment and eventually progressed into a stable rhythm.¹⁰³ But for the thousands of psychologically affected veterans, postwar life provided a continuous challenge made all the more difficult by their lingering wartime memories.

The First World War brought trauma to the forefront in an unprecedented manner. Those who bore psychological war wounds – individual soldiers – were the most affected. A mixture of socio-economic conservatism and postwar anxieties, fueled by the Depression, ensured Canadian veterans were provided with a firm message from government and physicians that the best cure for their ills was a “brisk immersion in civilian life.”¹⁰⁴ Pension officials and physicians were, Morton and Wright argued, “Men of their time, as convinced of the virtues of economic individualism as they were of scientific expertise. For able-bodied veterans, they believed, a swift transition to civilian self-sufficiency and their breadwinner role was the best way to remove the vestiges of soldierly dependency. Even for the disabled, the transition must be as swift as possible.”¹⁰⁵ Colloquially put, contemporaries believed that an age-old “pull yourself up by your bootstraps” mentality and return to their role as breadwinners would sort out veterans’ problems.

¹⁰¹ Morton and Wright, *Winning the Second Battle*, 104; Numbers of successful pension applications for shell shock are tricky, but where they are available there were on record in 1934 a total of 4021 temporary and 155 permanent pensions for “nervous system” injuries. See *ibid.*, 238; As noted by Copp and Humphries though, most of the 155 permanent pensioners were probably committed to provincial asylums. See Copp and Humphries, *Combat Stress*, 87.

¹⁰² Humphries, “War’s Long Shadow,” 520; Morton and Wright even went so far as to term the one-time payments sometimes granted to shell-shocked veterans as “deliberately punitive,” payments viewed by doctors as a “moral prosthesis” for the weak-willed. See Morton and Wright, *Winning the Second Battle*, 133.

¹⁰³ As Morton and Wright so aptly stated, “History keeps little record of those who did fit in.” See *ibid.*, 118.

¹⁰⁴ *Ibid.*, 100.

¹⁰⁵ *Ibid.*, 223.

Shell-shocked veterans, the “worst off” of those seeking pensions, had a difficult road, as their unseen injuries caused physicians and much of the lay public to designate them shirkers, malingerers, and inferior men.¹⁰⁶ In an era far removed from the standard double-income family of the twenty-first century, an early twentieth century man’s competence as a father and husband was intimately tied to his ability to provide.¹⁰⁷ As the sole family breadwinner, a veteran unable to provide for his family was not only viewed as a weak character, but also a failure as a man. Rigid standards of masculine behaviour and comportment, including a strong work ethic and willpower, were seen as crucial for maintaining the social order.¹⁰⁸ Nervousness, exemplified in the shell-shocked veteran, was deemed the behaviour of “weak and womanly men” and seen as a threat to society.¹⁰⁹ Thus, the “nervous” man remained a “principal foe of manliness” throughout the early twentieth century and beyond.¹¹⁰

Physicians and researchers studying “war neuroses,” on the other hand, greatly benefitted from the war, establishing themselves as the go-to experts on psychiatric/psychological illness, despite the evident lack of progression in definition or “cure.” With the emphasis placed on veterans’ heredity, predisposition, and character, the examination of individual case histories became invaluable for pension officials to separate the deserving from undeserving. Physicians were the natural experts for that task. For historians of trauma, the most pertinent legacies were the issues shell shock framed for future decades: The perceived causes of, and medical debates over trauma; the medico-psychological community’s role in defining such debates; the socio-economic considerations tied to traumatized soldiers, i.e. pensions and treatment, both of which became a public concern; and lastly, challenges to views of the ideal soldier and man that trauma

¹⁰⁶ Ibid., 75.

¹⁰⁷ Morton, *Fight or Pay*, 23.

¹⁰⁸ George Mosse, *The Image of Man*, passim.

¹⁰⁹ Ibid., 100; The shell-shocked veteran was also the victim of traditional prejudices about the mentally ill, and sometimes treated as such.

¹¹⁰ Ibid., 61.

brought to light. As the interwar period progressed and the Depression took hold, the public's focus was on basic necessities like food and employment. Shell-shocked veterans, whether in the asylum or struggling with civilian life, faded into the background. It took another war to bring discussions of trauma back into the public spotlight.

From Shock to Exhaustion

When the Allied nations entered the Second World War they had to re-establish many of the techniques used in “forward” psychiatry toward the end of the Great War.¹¹¹ During the enormous demobilization that took place after 1918, the relationship between psychiatrists and the military had largely disintegrated and thus had to be rebuilt.¹¹² War neurosis, or “battle exhaustion” as shell shock was rebranded in 1943, was initially dismissed as a significant concern in the Second World War, partly because combat in 1939-1940 was swift and decisive, leaving little time to set up organized structures for dealing with mental casualties. Allan Young characterized the classification of war neuroses in the Second World War as “too confusing to be properly interpreted by historians” and without a “Rosetta stone” to provide clear translation.¹¹³ Likewise in his 2007 essay on battle exhaustion in the Canadian Army during the Second World War, former CAF Reservist and Afghanistan veteran Ryan Flavelle opined, “Battle exhaustion is an easy condition to be sympathetic to, but a much more difficult one to understand.”¹¹⁴ Historians have long been challenged by the term's vague nature as well as the manner in which,

¹¹¹ Shephard, *A War of Nerves*, 205; Forward psychiatry involves the placement of psychiatrists at or close to the front, and the treatment of soldiers close to the front line, rather than at hospitals far behind the line or out of country. It relies on three principles: Proximity to battle, immediacy, and expectation of recovery, known as the PIE method or system. For more on its history see Edgar Jones and Simon Wessely, “‘Forward Psychiatry’ in the Military: Its Origins and Effectiveness,” *Journal of Traumatic Stress* 16, no. 4 (2003): 411-419.

¹¹² In reality, the entire army had to be rebuilt, as Canada entered the war with only 5000 professional soldiers.

¹¹³ Young, *The Harmony of Illusions*, 92-93.

¹¹⁴ Ryan Flavelle, “Help or Harm: Battle Exhaustion and the RCAMC During the Second World War,” *Journal of Military and Strategic Studies* 9, no. 4 (2007): 2.

like shell shock, battle exhaustion provided a blanket diagnosis for numerous manifestations of anxiety. Nevertheless, generalizations can be made. While during the early stages of the First World War shell shock was deemed the result of physical factors, by the Second World War the “pendulum had swung almost entirely in the other direction.”¹¹⁵ In 1939 most physicians believed war neuroses originated in the mind (psychogenic).¹¹⁶

As in the First World War, most military officers tried to reject psychiatrists’ integration within the military hierarchy. Their rationale was by then well-established: Whatever the chosen term, psychiatrically-sanctioned war neurosis provided soldiers an alternative to fighting.¹¹⁷ Resistance was also partly based on a social-psychological and sociological approach to human behaviour that developed between the wars and placed importance on strong leadership and primary group relationships – in the military’s case, a strong esprit de corps.¹¹⁸ Military officers believed a strongly led and tightly-knit group was less likely to break in combat, thus preventing psychological breakdowns as well. That approach also had medical backing. Influential journals like the *Lancet* promoted the idea that a man’s constitution and connection to the unit were paramount in determining his likelihood of cracking during or after combat.¹¹⁹ But in spite of military leaders’ apprehension, the long, intermittent, and brutal nature of the Second World War meant that psychiatrists and psychologists were eventually perceived as an unwanted but necessary part of casualty management.¹²⁰

A few researchers noticed early in the war that trauma was again becoming a focal point of discussion. American psychoanalyst and Sigmund Freud devotee Abram Kardiner stated in his 1941 work *The Traumatic Neuroses of War* that with regards to manifestations of war neurosis in

¹¹⁵ Ibid., 4.

¹¹⁶ Ibid.

¹¹⁷ Binneveld, *From Shell Shock to Combat Stress*, 101.

¹¹⁸ Ibid., 96.

¹¹⁹ Flavelle, “Help or Harm,” 4.

¹²⁰ Shephard, *A War of Nerves*, 205.

soldiers of the Second World War, “the symptomatology [symptom profile] of this syndrome is no different today than it was during the last war.”¹²¹ Like numerous colleagues, he believed that modern war “introduced certain conditions conducive to neuroses in those so predisposed.”¹²² Kardiner’s research and work with traumatized soldiers convinced him that in every war there were soldiers who suffered long-term psychological effects. He was unequivocal in his statement that, “One of the certainties with which a warring nation must contend is that at the termination of the conflict there will be a considerable number of problems dealing with those soldiers who return more or less damaged.”¹²³ For psychiatrists and psychologists the debate still hinged on whether the persistent character of psychological trauma in some soldiers was due to predisposition, by 1939 largely tied to life-history and upbringing, or whether every man had a breaking point.

Despite its prescience Kardiner’s book went largely unnoticed for three more decades.¹²⁴ In the military milieu, the potentially troublesome nature of trauma was downplayed by medical officers and leaders who believed that well-trained units minimized mental breakdowns, even in sustained bouts of combat.¹²⁵ If breakdowns did occur, soldiers were to be treated close to the front with rest, an immediate medical response to the trauma, reassurance from physicians about their prognosis, and firmness about their duty to return to combat. That method, developed during the second half of the First World War, became known as the PIE system (Proximity of treatment to the battlefield, Immediacy of response, Expectancy of a rapid return to the unit and

¹²¹ Kardiner, *The Traumatic Neuroses of War*, 6; Kardiner was personally (psycho)analyzed by Freud.

¹²² Ibid., 69; Kardiner’s ideas reflected the gradual rise of Freudian psychology and dynamic psychiatry in mainstream American psychiatric circles. In both America and Canada shifts in psychology’s orientation (in Canada it was somewhat less Freudian) led to the displacement of previous hereditary views of mental illness, something by the 1930s associated with degeneration and eugenics. For more on developments in psychology and psychiatry during the late-nineteenth and early- to mid-twentieth century see Shorter, *A History of Psychiatry*, 145-189.

¹²³ Kardiner, *The Traumatic Neuroses of War*, 233.

¹²⁴ Kardiner’s book later became a focal point for researchers who convinced the psychiatric mainstream to accept the idea of PTSD.

¹²⁵ Copp and Humphries, *Combat Stress*, 126.

recovery.¹²⁶ PIE was used with some success in the later stages of the First World War, again in the Second World War, and is still a generally accepted system in use by militaries in the twenty-first century.¹²⁷ Under such a system, army officers believed no specialists were needed, except for serious cases treatable by distant neuropsychiatric hospital units.¹²⁸ For the military what mattered most was, as always, preserving manpower. Psychiatrists were disruptive to this goal because they removed men who, in officers' eyes, simply needed a quick rest and firm pat on the back. Even Winston Churchill was skeptical of wartime psychiatry, believing psychiatrists to be a burden on the army and their work capable of descending into "charlatanry."¹²⁹

A Rude Awakening

The British at Dunkirk in May 1940 were the first Commonwealth nation to feel the full brunt of war, and the psychological effects on surviving soldiers provided clues that even seemingly "normal" and well-trained individuals could break under intense pressure. Pushed by the Germans back to the French port of Dunkirk, 250,000 British Expeditionary Force troops waited for evacuation while enduring sleeplessness, shelling, and bombing by German Stuka dive bombers. The effects on men's psyches were evident: one soldier proclaiming he was Mahatma Gandhi and another remaining absolutely still while protecting an imaginary basket of eggs were just a few examples of the troops who had reached their breaking point.¹³⁰ Dunkirk

¹²⁶ This concept was first employed by the French in 1915, and later developed by the American psychiatrist Thomas Salmon in 1918. See Jones and Wessely, *Shell Shock to PTSD*, 24-25; The acronym was later created by K.L. Artiss. See K.L. Artiss, "Human Behaviour under Stress: From Combat to Social Psychiatry," *Military Medicine* 28, no. 10 (1963): 1011-1015.

¹²⁷ Despite the success of PIE, the question of whether a soldier who is able to function again in combat will be healthy in the long term is another matter.

¹²⁸ Ibid.

¹²⁹ Shephard, *A War of Nerves*, 195.

¹³⁰ Ibid., 169.

tested the assumption that no forward psychiatrists were needed. It also poked holes in the view that combat breakdowns were attributable to a soldier's weak disposition.¹³¹

On 6 July 1940 William Sargant and Eliot Slater, two civilian physicians working for the Sutton Emergency Hospital in London, published a report on the treatment of military war neuroses seen after Dunkirk.¹³² They made an important distinction between "acute shell shock" seen after Dunkirk in numerous seemingly normal men, and neuroses seen in soldiers during the Phoney War before May of 1940. Their study generated interesting insights: First, they recognized that under enough physical and mental strain, and numerous traumatic events such as the sight of dying comrades, even men with solid work records, high intelligence, and normal personalities could "crack." Second, they noted that even with regard to intense anxiety states the symptoms were usually of a short duration. Lastly, they wrote that the longer soldiers' symptoms were allowed to persist without treatment the greater the chance their thoughts and behaviour patterns became ingrained.¹³³ Sargant and Slater's treatment plan involved inducing a hypnotic state in patients with the widely used sedative, sodium amytal, after which time they attempted a "recovery of amnesia," a "reinforcement of suggestion," and "the relief of hysterical symptoms."¹³⁴ Psychiatrists believed that method helped the patient relive and work through the repressed traumatic events – a process called abreaction – while also preventing the nervous system from incurring further stress. In a publication several decades later, Sargant expressed his

¹³¹ Copp and Humphries, *Combat Stress*, 126; Of course, it is questionable if psychiatrists could have made any difference in the Battle of Dunkirk, given the conditions and its relatively short duration.

¹³² Ibid., 127; The Sutton was a sub-unit of the eminent Maudsley Hospital in London which had been evacuated in 1939. It is worth noting that the reason two civilian physicians were caring for military men was due to the fact that the British Army had made no provisions for mentally ill soldiers at home. This was perhaps more telling of the prevailing attitude and optimism about war neuroses than anything else. Sargant later became (in)famous for his consultation with those working with the CIA for the MKULTRA mind control program, as well as his "missionary zeal" for psychosurgery. He consulted with McGill psychiatrist Ewen Cameron on many occasions. See Shephard, *A War of Nerves*, 337; and for his connections to Cameron see Gordon Thomas, *Journey into Madness* (London: Bantam Press, 1988), 189-190; and also John Marks, *The Search for the "Manchurian Candidate": The CIA and Mind Control* (New York: Times Books, 1979), for more on the MKULTRA program.

¹³³ Copp and Humphries, *Combat Stress*, 127.

¹³⁴ Ibid., 128.

belief that Dunkirk demonstrated the folly of trying to quickly “patch up” soldiers and send them out to battle again, given that battle was what caused their break down in the first place. Citing the First World War, he pointed out that even the threat of firing squad and execution of those deemed cowards was not enough to prevent break down in soldiers under intense and continuous stress.¹³⁵

After Dunkirk, it was not until a few years later, during the battles in the Middle East and North Africa, that the British Army was forced to acknowledge that a number of men were breaking down due to what they believed was fatigue and nervous exhaustion.¹³⁶ British Army Consultant Psychiatrist G.W.B. James, a veteran of the Somme and Passchendaele, encountered a situation when he arrived in 1940 that reminded him of the early First World War. He was dismayed to find no “modern” program for psychiatric casualties, and felt that army physicians “had no conception of breakdown in war and its treatments, though many of them had served in the 1914-18 war.”¹³⁷ By 1942, when forward psychiatry was finally put in place, he was certain there were limitations on what a soldier could endure. Convinced by his examination of fifty psychiatric casualties in July 1942 that much of the problem stemmed from the physical toll of modern warfare (and especially the desert) on a soldier, he changed use of the term “Not Yet Diagnosed – Nervous (NYDN)” to “physical exhaustion,” and then to “battle exhaustion.” Similar to how shell shock captured the shattering effect of shells on soldiers’ bodies and minds during the First World War, battle exhaustion encompassed and symbolized the physically and mentally exhausting effects of the Second World War on infantrymen.¹³⁸

¹³⁵ Ibid.

¹³⁶ Ibid., 129.

¹³⁷ Shephard, *A War of Nerves*, 183.

¹³⁸ Binneveld, *From Shell Shock to Combat Stress*, 83; Battle exhaustion carried similar connotations to neurasthenia, since both implied an exhaustion of the nervous system and its energy. Neurasthenia was largely reserved for officers of the First World War, since it carried less of a stigma than shell shock, on account of the belief that the man whose nervous system was depleted had fought long and hard before succumbing to breakdown.

Although the British Army was forced to accept the reality of battle exhaustion and other forms of mental breakdown among troops, it did so very grudgingly, assigning battlefield psychiatry a very low priority throughout the war. Among General (later Field Marshal) Bernard Montgomery's staff, as but one example, there was a prevailing belief that psychiatry was something akin to witchcraft.¹³⁹ Thus, for the war's duration, despite occasions such as in July 1944 when a group of infantry in Montgomery's 21 Army Group suffered a 25% battle exhaustion casualty rate, military leaders continued to attribute mental breakdowns more to swings in morale from a long, tough campaign, rather than to the nature of combat.¹⁴⁰ There was a link between the duration and intensity of battle, troops' experience level, and the number of battle exhaustion diagnoses, but the military had a desire to downplay numbers. In a testament to the resilience of the human mind and spirit, most symptoms of trauma, as predicted by Sargant, were relatively short in duration; or so it seemed.

Military leaders' optimism about battle exhaustion rates also reflected a hitherto unmentioned development of the interwar and early Second World War period. While psychiatrists were busy digesting the lessons of the First World War during the post-1918 years, psychologists were equally busy researching human behaviour, and more importantly for any use in a military context, developing tests to screen out those "predisposed" to breakdown. Simply put, while psychiatrists focused on emotional and behavioural pathology, psychologists claimed expertise on normalcy and personality development.¹⁴¹ Given an adherence by numerous psychologists to the hypothesis that breakdowns could be accurately predicted by personal and

It is interesting to note that the RAF and RCAF, instead of battle exhaustion, used the term "Lack of Moral Fibre" to classify men who had broken from the strain of too many sorties or could not fly for unjustifiable reasons. See Allan English, *The Cream of the Crop*, 81.

¹³⁹ Copp and Humphries, *Combat Stress*, 145.

¹⁴⁰ *Ibid.*, 148-149.

¹⁴¹ There was some evident overlap. For more on these developments in Canada see Mona Gleason, *Normalizing the Ideal*, 6-8.

family histories as well as deviant behaviours like drug use, they affirmed that with proper testing most of the “unfit” men could be weeded out before induction. That approach, in theory, saved the military time and money on training “neurotic” men and lowered the incidence of mental breakdown in combat. The problem with such a belief though, was that it conflated two different issues: stress and mental disorder, and mental “deficiency” and mental disorder.¹⁴² A seemingly normal man breaking down because he “had enough” or because he was exposed to traumatizing events was different in kind from an individual with a pre-existing, latent mental disorder cracking because he was inherently less able to cope with mental duress. Sargant and Slater’s distinction between “acute shell shock” and “neurosis” was an important one, since it made clear that many men who had broken down during the Phoney War (in which no combat was seen) were not of the same category as those who had been unable to continue because of trauma. Unfortunately, it was easy to confuse the two, and researchers were limited in their ability to neatly categorize the myriad ways in which mental capacity and behaviour expressed themselves.

Both the British and Canadian armies rejected intelligence testing and psychiatric assessment for recruits at the beginning of the war.¹⁴³ Each nation went in its own direction, but they shared some general beliefs and trends. Physicians took away from the First World War the lesson that a rigorous selection process was necessary due to the number of ostensible “misfit” men who made it into uniform, but putting measures into place to prevent a similar recurrence was a mammoth task. Questions such as what criteria should be used to assess a man’s fortitude for service, and whether that assessment should be made by an army officer, military physician,

¹⁴² Shephard, *A War of Nerves*, 188.

¹⁴³ Copp and Humphries, *Combat Stress*, 131.

or a civilian psychologist, were thorny.¹⁴⁴ Military leaders at first opted for the safest option for bringing in the highest number of troops, which was no testing or screening at all. In the Canadian case, the decision to forego screening measures was a reflection of the medical profession's attitude toward psychiatry and psychology. The majority of civilian and military doctors believed that well-trained physicians, particularly those with previous war service, could evaluate a soldier's character and fortitude just as effectively as specialists.¹⁴⁵ Dr. John Griffin, long-time CMHA president and consultant to psychiatrist Brock Chisholm during the war, stated that "The medical profession, including those in Canadian Medical Corps ... seemed even anti-psychiatric in attitude."¹⁴⁶ Thus, when the Canadian military entered the war, leaders believed their own selection process, which consisted of a very rudimentary screening that inadvertently put men with mental illness and physical disabilities into uniform, was sufficient.¹⁴⁷

The British Army initially approached personnel screening with similar attitudes, and was the first to see its consequences. After Dunkirk, the British implemented a testing and screening program with the help of psychiatrists and psychologists, partly in response to criticism from publications like the *Lancet*, which claimed that more men were breaking down from pre-existing neurotic disorders than from combat; an obvious indicator that the Army's ad hoc

¹⁴⁴ Shephard, *A War of Nerves*, 187.

¹⁴⁵ Copp and Humphries, *Combat Stress*, 126.

¹⁴⁶ John Griffin, *In Search of Sanity: A Chronicle of the Canadian Mental Health Association 1918-1988* (London, Ont.: Third Eye Canada, 1989), 101; The Canadian Mental Health Association, then still termed the Canadian National Committee for Mental Hygiene, for its part sent informal bulletins throughout the war dealing with wartime psychiatry. By the end of the war information was being sent to 250 military psychiatrists, psychologists, and medical officers in Canada and overseas. See *ibid.* Griffin played a large role in the expansion of the Army's psychiatric branch, including the establishment of training courses in psychiatry at McGill and the University of Toronto. Regimental medical officers who had served at least six months in the Army were eligible for the seven month program. On top of course work, the training included a month in a veterans' hospital and two months at a military establishment. Those "fledgling psychiatrists" provided the manpower for the development of the Canadian Army's psychiatric program between 1943 and the end of the war. See Terry Copp and Bill McAndrew, *Battle Exhaustion*, 34-35.

¹⁴⁷ Copp and Humphries, *Combat Stress*, 125.

screening method was ineffective.¹⁴⁸ Psychiatrists in particular gained traction within the British Army between 1940 and 1942, “advising on a range of issues that went well beyond usual definitions of psychiatry.”¹⁴⁹ They were even allowed to create their own medical division at Whitehall. Nevertheless, the power of commanders on the ground meant that throughout the war psychiatric casualties were dealt with inconsistently and in a manner largely dependent on officers’ whims.¹⁵⁰ Psychiatrists were, in practice, never entirely welcomed in any Allied army. Perhaps the best symbolic – and literal – rejection of psychiatric casualties came from American Lieutenant-General George S. Patton Jr., who in 1943 infamously slapped one mentally affected soldier with his glove, calling him a “goddamned coward.” One week later he threatened another with his pistol and punched the man on the head.¹⁵¹ Patton’s frustration partially stemmed from the “wastage” that occurred during the Sicily campaign, and his actions exemplified a reticence among military leaders to acknowledge the reality of mental casualties, despite mounting evidence in both world wars.¹⁵²

In Canada, psychological testing gained ground in 1941 when Minister of National Defence J.L. Ralston took an interest in the potential benefits of intelligence and aptitude measurement. By the Second World War psychology and intelligence testing had attained a foothold in Canadian schools and social welfare institutions, in part because of its relationship with the mental hygiene movement and CNCMH throughout the 1920s and 1930s.¹⁵³ The

¹⁴⁸ Shephard, *A War of Nerves*, 188; see pages 187-203 for a detailed description and analysis of the British and American screening systems.

¹⁴⁹ Young, *The Harmony of Illusions*, 92-93.

¹⁵⁰ Ibid; The myriad ways in which commanders viewed and handled psychiatric casualties was in part the reason for Young’s statement about the story’s complexity.

¹⁵¹ Shephard, *A War of Nerves*, 219; The “slapping incident” was dramatically recreated in the 1970 biopic film *Patton*.

¹⁵² Shephard, *A War of Nerves*, 219.

¹⁵³ That relationship involved research and initiatives in the mental hygiene movement, and of course its darker expression – eugenics. For more on Canadian developments see Mona Gleason, *Normalizing the Ideal*, 19-36; Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885-1945* (Toronto: McClelland & Stewart, 1990),

discipline's forays into the war effort were a reflection of its incipient growth and influence. E.A. Bott, chair of the psychology department at the University of Toronto and president of the newly formed Canadian Psychological Association, went to Britain to consult with the Canadian Army overseas and report on British research.¹⁵⁴ Bott later joined the Royal Canadian Air Force, and his studies on Canadian aircrew, told in great detail in Allan English's 1996 book *The Cream of the Crop*, came to similar conclusions as numerous army psychiatrists: given enough cumulative stress, any man would break, and treating men away from the battlefield turned most "curable" patients into chronic cases.¹⁵⁵ Psychological testing was given its biggest boost when the charismatic and larger-than-life Colonel and psychiatrist George Brock Chisholm was put in charge of a new directorate of personnel selection in 1941.¹⁵⁶

The directorate was established to create a comprehensive system of personnel selection. Its goals were: to classify all Army personnel; identify potential officer material; identify those of higher intelligence; uncover "neurotics;" and weed out men deemed to be of lower intelligence. The directorate's aims mirrored several initiatives in civilian circles, and clearly expressed psychologists' expanding ambitions.¹⁵⁷ Though a psychiatrist, Chisholm espoused many "neo-Freudian theories of sexuality" and as an adherent of the mental hygiene movement saw psychology's value in preventing "mental weaklings" from entering the Army.¹⁵⁸

Chisholm's plan was not without controversy though, and revealed professional jockeying

passim; Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013), chs. 1,2,3.

¹⁵⁴ Copp and Humphries, *Combat Stress*, 132; The Canadian Psychological Association was formed in 1938.

¹⁵⁵ English, *The Cream of the Crop*, 64.

¹⁵⁶ Chisholm was the first private psychiatric practitioner in Canada (1934), and became the first Director-General of the World Health Organization in 1948.

¹⁵⁷ Copp and Humphries, *Combat Stress*, 135.

¹⁵⁸ Ian Dowbiggin, "'Prescription for Survival': Brock Chisholm, Sterilization, and Mental Health in the Cold War Era," in James Moran and David Wright, eds., *Mental Health and Canadian Society: Historical Perspectives* (Montreal & Kingston: McGill-Queen's University Press, 2006), 178; Copp and McAndrew likewise assessed Chisholm's approach as "Freudian-influenced psychiatric practice." See Copp and McAndrew, *Battle Exhaustion*, 8.

between psychologists and psychiatrists. Colin Russel, the shell shock expert, was now Consulting Neuropsychiatrist to the Royal Canadian Army Medical Corps (RCAMC) and believed that the number of men referred for psychiatric examination based on their psychological test results was excessive.¹⁵⁹ It was his opinion that psychologists were better suited to identifying and reassigning men who, based on perceived capabilities, were being misused by the Army. Put another way, he intimated that psychologists were out of their depth.¹⁶⁰ Somewhat chastened by his experiences, Russel was convinced that attempting to identify potential “neurotics” through psychological testing was a fruitless endeavour.¹⁶¹

Nonetheless, the support psychological testing received from Chisholm and Ottawa meant that in 1942 personnel selection officers were given a mammoth task: conduct a psychological examination and psychiatric history covering family, school, employment, and other factors such as sexual adjustment, of all Canadian troops overseas.¹⁶² Chisholm, who was no stranger to controversy, believed an undue feminine influence during childhood rearing was a prime reason numerous men were unfit for military service. In two speeches on 11 February 1944 given before the Rotary Club and Welfare Council of Toronto, he affirmed: “Too many women are bringing up too many boys on women’s values.”¹⁶³ He argued women were “not oriented toward society. They are oriented toward men.” That orientation, in his estimation,

¹⁵⁹ Copp and Humphries, *Combat Stress*, 136.

¹⁶⁰ Ibid.

¹⁶¹ Ibid; The rivalry between psychiatrists and psychologists was a reflection of challenges to the former’s dominance over the mental health profession resulting from the latter’s rise as a distinct and organized discipline in the preceding decades. See Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), 264-265.

¹⁶² Copp and Humphries, *Combat Stress*, 137; The emphasis on sexual adjustment belied Chisholm’s Freudian leanings.

¹⁶³ *The Globe and Mail*, 12 February 1944; Chisholm espoused many opinions considered outlandish or strange by twenty-first century standards. He is famous for arguing that parents needed to get rid of the Santa Claus myth because “We know what myths and magic do to people.” In a speech at the New York Psychoanalytic Society and the New York Psychoanalytic Institute in 1946, he affirmed that the fact that “hardly a hotel in New York has a floor numbered 13” implied “enormous and disturbing” things. He seems to have spotted neuroses in many ostensibly benign traditions. See *The Globe and Mail*, 26 October 1946.

weakened men's sense of obligation to their community and made women a liability, particularly in wartime. Thus weakening mothers' influence over men was the best strategy for helping recruits adjust to army life.¹⁶⁴ Given women's extensive involvement in the war effort, Chisholm's opinions unsurprisingly caused a "furor stirred in women's circles," many of whom felt he had denigrated their contributions.¹⁶⁵ The subsequent fallout led Defence Minister Ralston to make a "clarification" in the House of Commons on Chisholm's behalf.

In a *Globe and Mail* article covering the controversy several days later, the author defended Chisholm's view, stating, "The records of this war indicate that, emotionally and psychologically, many young Canadians went into uniform badly equipped for war."¹⁶⁶ Echoing Chisholm's earlier statements, the author continued: "It has been pretty well established by the psychiatrists, in their search for weaknesses which develop in later life, that some men are the victim of a 'mother complex.'"¹⁶⁷ The result was that "today cases of war neurosis are treated according to the basic causes, often present in the individual from early childhood."¹⁶⁸ Evidently, Chisholm's theories of childhood development and women's influence on a soldier's psychological profile had supporters among the lay public. Statements about the negative influence of overbearing mothers helped relocate the blame for war-related mental disorder from traumatic wartime events to individual failings, and at a societal level, to the women who predisposed men to their failed masculinity.¹⁶⁹ Thus, in the mood of optimism about the

¹⁶⁴ Chisholm's expression of "Momism" reflected a larger trend evident during the 1930s, 1940s, and beyond. During that time psychiatrists, psychologists, and other experts deemed the war's social upheaval and a subsequent shifting of gender roles as the cause of men being emasculated and made into "girly men." Numerous scholars have examined anxieties about socio-economic changes and shifting gender roles. For two Canadian examples see Gleason, *Normalizing the Ideal* and Christopher Greig, *Ontario Boys*.

¹⁶⁵ *The Globe and Mail*, 17 February 1944.

¹⁶⁶ Ibid; Author unknown.

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

¹⁶⁹ Hazel Croft, "Emotional Women and Frail Men: Gendered Diagnostics from Shellshock to PTSD, 1914-2010," in Ana Carden-Coyne, ed., *Gender and Conflict since 1914: Historical and Interdisciplinary Perspectives* (Basingstoke: Palgrave Macmillan, 2012), 133.

“progress in the 20 years between the two wars,” Chisholm and his supporters decided to proceed with psychological testing and a combing of soldiers’ life histories, to find out those who bore the mark of excess femininity and mental weakness.¹⁷⁰

In practice though, many psychologists and psychiatrists were tolerant of difference and exercised circumspection about the varying degrees of masculinity, as well as shrewd suspicions about the connection between men’s subjectively assessed masculinity and its use as a prediction of combat performance. As the war progressed, it became clear that ostensibly “feminine” men often performed well in combat, and conversely, “masculine” men sometimes failed the test of war. Historian Paul Jackson’s work on homosexuality in the Canadian military during the Second World War demonstrated that throughout the war, particularly in 1944 and beyond as frontline manpower became a concern, psychiatrists often looked the other way, even when faced with openly homosexual and “effeminate” recruits. Likewise homosexuals who had been tested in battle and proved themselves good soldiers were often spared medical discharge, even in cases when their homosexuality became known to physicians and was no longer an open secret known only within their unit.¹⁷¹ Despite official policies that were hostile to homosexual men and women within the military, homosexuals were usually deemed too valuable to the war effort to be considered a problem unless their behaviour was particularly egregious or it became a scandal for officers and higher authorities.¹⁷² Psychiatrists’ handling of homosexuality was a reminder that arbitrary assessments of a man’s character, especially those involving judgements about masculinity and femininity, were fluid, and the way a soldier performed in battle and his

¹⁷⁰ *The Globe and Mail*, 17 February 1944.

¹⁷¹ Paul Jackson, *One of the Boys: Homosexuality in the Military during World War II* (Montreal & Kingston: McGill-Queen’s University Press, 2004), passim, esp. chapters one and three.

¹⁷² And, as Jackson shows, sometimes even scandal could be dispelled if a man’s service had been particularly distinguished and he was well liked by his unit. Jackson’s work is a reminder that with regard to homosexuality and 1940s gender pronouncements, a man’s “true” masculinity and acceptance within his unit was ultimately determined by his performance in battle. A homosexual man, like the shell-shocked soldier, could prove himself to be a “real” man and overcome prejudices about his character if he stayed the course and fought well with his comrades.

value to the unit were the prime factors in whether or not his “femininity” became a problem for authorities.¹⁷³

When Chisholm was appointed Director General of Medical Services in 1942, and later Deputy Minister of Health, it was clear his star, and his views, were on the rise. In 1943, personnel selection officers were ready to “reclassify” and re-examine the entire Canadian Army overseas, but the plan was scuttled when the tides of war sent the 1 Canadian Division to the Mediterranean and other units became focused on training for Operation Overlord, the future D-Day landings.¹⁷⁴

The Canadian military and Ottawa were not oblivious to psychological trauma and psychiatric casualties prior to Canada’s engagement in combat.¹⁷⁵ Only five months into the war, in January 1940, Ottawa announced the planned establishment of a neurological hospital behind the front lines in France, a “spearhead of a scientific drive to reduce the heavy toll taken by nervous disorders in wartime.”¹⁷⁶ The hospital was to include several prominent Toronto and Montreal doctors and nurses. It was to be headed by Colin Russel, then neurological consultant to the Medical Services and professor of neurology at McGill, and was to treat both brain injuries and nervous disorders.¹⁷⁷ Medical authorities believed the hospital would be “an important factor in reducing postwar pension costs.”¹⁷⁸ Reflecting perceived advances since the Great War and perceptions of neuropsychiatry’s role as preventive medicine, they affirmed that, “men suffering

¹⁷³ Ibid., passim.

¹⁷⁴ Copp and Humphries, *Combat Stress*, 137.

¹⁷⁵ Copp and Humphries described the Canadian battle exhaustion experience, at least in Normandy, as “fairly typical of the overall Allied experience,” though Shephard argued that the Canadians had a particularly tough time. Cf. Copp and Humphries, *Combat Stress*, 149; Shephard, *A War of Nerves*, 254-255.

¹⁷⁶ *The Globe and Mail*, 3 January 1940.

¹⁷⁷ This situation reflected the fact that before 1939 the treatment of neuroses, at least in academic medicine, was almost exclusively the domain of neurologists in general hospitals. Thus, neurologists and neurosurgeons were put in one place, and the former given the title neuropsychiatrists. See Copp and McAndrew, *Battle Exhaustion*, 15.

¹⁷⁸ Ibid; In fact, the article made two references to the implied financial savings. According to Copp, the contrast between the Army’s resistance to psychological testing and its affirmative response to Russel’s proposal was a measure of the status he held in the Canadian medical profession. See Copp, “The Development of Neuropsychiatry in the Canadian Army,” 69.

from various types of hysteria who in the last war spent months and even years in hospitals will this time be discharged fully fit for duty in a matter of days.”¹⁷⁹ The author cited the example of a neurological hospital for Canadian troops in England set up toward the end of the First World War, noting that 71% of cases were able to return to full duty in six months. Similar results were expected in 1940.¹⁸⁰ Reinforcing the primacy of early treatment in ensuring recovery, the article summarized the specialist’s crucial role in that process: “[T]o give the patient a new philosophy to overcome his troubles before something, which doesn’t exist physically, succeeds in making a physical wreck of a man.”¹⁸¹

For Russel, the “secret of psychotherapy” and cure for battle exhaustion was a “mental contest resulting in the victory of the physician.”¹⁸² As was so often the case in both world wars, unforeseen events changed the Army’s best laid plans, and several months later the German Blitzkrieg swept the Allied forces off the continent. Russel and his staff, who arrived in Britain just as the Dunkirk evacuation was taking place, were instead located in a spacious mansion near Basingstoke in Hampshire, England. The 200 bed hospital they established there became known as No. 1 Neurological and Neurosurgical Hospital, or simply Basingstoke.¹⁸³ Colloquially, many troops referred to Russel, his colleagues and the hospital itself as “No. 1 Nuts.”¹⁸⁴ Their original structure as a mobile hospital accompanying the Army was altered, and they instead found themselves treating civilian victims of the Blitz, Dunkirk evacuees, and Canadian soldiers injured (and psychologically affected) by the numerous motorbike accidents that occurred during the night time blackout. Those early experiences, many with civilians and soldiers who had not

¹⁷⁹ Ibid.

¹⁸⁰ It is unclear where the author took his statistics from, but it might have been a reference to Granville Canadian Hospital. Colin Russel made reference in his 1919 article (cited above) on “The Management of Psycho-Neuroses in the Canadian Army” to “upwards of 60% of the patients” in 1917 being returned to the front.

¹⁸¹ Ibid.

¹⁸² Colin Russel, “The Nature of the War Neuroses,” *Canadian Medical Association Journal* 41, no. 6 (1939): 554.

¹⁸³ For a fuller account of Basingstoke see Copp and McAndrew, *Battle Exhaustion*, 16-17.

¹⁸⁴ Ibid., 16.

seen combat, convinced Russel and his staff that their belief in the predisposition hypothesis of neuroses was correct.¹⁸⁵ If men broke down without seeing battle, it stood to reason that the cause of their illness must stem from “constitutional predisposition.”

¹⁸⁵ Ibid, 16-18.

CHAPTER 2: BATTLE EXHAUSTION AND MEDICAL MOVEMENTS

The question at issue is of some consequence in war. If a man is rested in time will he have another summer of high achievement, or if that is only a forlorn hope is it more sensible to cut losses? To put it differently, can a good fellow who is showing signs of wear and tear come back?¹

Although Canadian combat units had little experience until the Sicily campaign in 1943, their grueling battles in the Mediterranean and Western Europe after D-Day caused numerous troops to end up mental casualties, in spite of initial optimism among military leaders and medical men. During the Italian campaign alone, the Canadian Army suffered 5020 neuropsychiatric casualties, out of a total of 25,090 casualties.² Canadian author Farley Mowat, a second lieutenant in The Hastings and Prince Edward Regiment (the “Hasty Ps”), wrote a first-hand account of his regiment’s duress in his 1955 book *The Regiment*, and later his 1979 memoir *And No Birds Sang*.³ In *The Regiment*, Mowat made direct reference to witnessing his comrades visibly affected after a particularly tough battle against German troops during the Moro River Campaign in mid-December 1943. He wrote: “These men were beyond pride, beyond praise, beyond condemnation. They were empty of all emotions and knew nothing except for a stupefying weariness. The medical officers had a term for individuals who had reached the end of their tether. They called it ‘battle exhaustion’ and it was a polite term that meant ‘burned out.’”⁴ One could easily read this passage and, save for the term “battle exhaustion,” mistake it for a description of the effects that First World War “shell shock” had on numerous men. Subsequent to one particularly savage battle, after tallying the regimental deaths, Mowat

¹ Lord Moran, *The Anatomy of Courage*, 77.

² The Canadians had of course been decisively defeated at Dieppe in 1942. A psychological study (discussed in a footnote below) many decades later hinted that many veterans of the Dieppe Raid still carried the psychological scars of battle. Neuropsychiatric figures are taken from Copp and McAndrew, *Battle Exhaustion*, 187.

³ Farley Mowat, *The Regiment* (Toronto: McClelland & Stewart, 1955); Mowat, *And No Birds Sang* (Madeira Park: Douglas and McIntyre, 2013 [1979]); Mowat was eventually promoted to Captain.

⁴ Mowat, *The Regiment*, 333.

lamented that, “Physically the exhaustion of the Regiment was just short of total ... Spiritually, the wastage had been even greater.”⁵

Within Mowat’s books there were numerous examples of traumatic events and their effects, including the witnessing of a tank officer struggling to pull himself from a burning tank turret – and failing – as the flames consumed him.⁶ In another passage, Mowat discussed terror’s effect on a soldier who took refuge in a nearby house to escape enemy shells: “Under the stairs was a human being, but not human in its abject terror. It was a soldier, crouched hard against the wall, and weeping bitterly and piercingly into cupped hands.”⁷ He laconically reported the reaction of combat-hardened soldiers familiar with such terror, affirming “they, too, did not forget.”⁸ Perhaps most evocative was a description of a thirty-five-year-old stretcher-bearer who broke under the strain of battle. Amidst the night-time explosion of mortar bombs, Mowat caught sight of the man: “Stark naked, he was striding through the cordite stench with his head held high and his arms swinging ... He was singing ‘Home on the Range’ at the top of his lungs. The Worm That Never Dies [fear] had taken him.”⁹ In the days that followed, Mowat noted that ambulance jeeps were constantly on the move, and for the first time since the regiment had gone to war, “they also carried casualties who bore no visible wounds.”¹⁰ He also wrote of how he was warned about psychological casualties in a letter from his father, a First World War veteran, who called them “the most unfortunate ones” who “had their spiritual feet knocked out from under them.” Mowat’s father wrote to him, seemingly with a mixture of pity and anger, that, “The beer

⁵ Ibid.

⁶ Ibid., 101.

⁷ Ibid., 130.

⁸ Ibid.

⁹ Mowat, *And No Birds Sang*, 215.

¹⁰ Ibid., 216.

halls and gutters are still full of such poor bastards from my war, and nobody understands or cares what happened to them.”¹¹

Lessons Slowly Learned

Like the poets and novelists of the First World War, Mowat captured the spirit of a war that, despite its occasional lighter side (he was keen to also note the humorous moments), left an indelible imprint on participants' minds. As with its allies the Canadian Army entered combat in 1943 poorly prepared to deal with battle exhaustion, despite its experiences during the First World War.¹² Terminology was also initially chaotic before 1943 and carried pseudo-scientific connotations. Many men were labelled “psychopathic personality, inadequate,” “grossly inadequate personality,” or “inadequate with added battle neurosis” before battle exhaustion became the preferred diagnosis.¹³ Rather than the Second World War being a watershed moment in the way that psychological trauma and casualties were understood, the official medical history of the war expressed that the same diagnostic and treatment methods of 1914 to 1918 were retrieved and slightly advanced.¹⁴ In fact, when the 1 Canadian Infantry Division went to action in Sicily in 1943, its preparation for mental casualties consisted of one psychiatrist.¹⁵ What was

¹¹ Ibid., 217.

¹² Copp and McAndrew, *Battle Exhaustion*, 9.

¹³ Copp and Humphries, *Combat Stress*, 139-140; Those labels were a byproduct of the focus on testing and reclassifying soldiers prior to the invasion of Sicily. According to Copp and Humphries, Army psychiatrists were deeply embarrassed by them after the war. See *ibid.*

¹⁴ Copp and McAndrew, *Battle Exhaustion*, 149.

¹⁵ To put this number in perspective, an infantry division at full strength in World War Two numbered 18,376 officers and other ranks, of which infantry made up 8,148 and medical staff 945. Although divisions never operated at full strength, especially during the war, one psychiatrist still seems exceedingly low. Divisional numbers were taken from J.L. Granatstein and Dean Oliver, *The Oxford Companion to Canadian Military History* (Toronto: Oxford University Press, 2011), 155-157; It should also be noted that Sicily was the first time that a Canadian field formation went into battle with a psychiatrist on strength.

unique about the Second World War was that psychiatrists were, when present, more closely attached to the division and their relationship with the administrative authorities was tighter.¹⁶

Taking their cue from the British, in October 1943 the Assistant Director of Medical Services, acting on the advice of neuropsychiatrists, issued instructions that all suspected neuropsychiatric cases be labelled with the temporary diagnosis of “exhaustion” (eventually “battle exhaustion”) until seen by a specialist.¹⁷ That decision was made because the term “carried no stigma,” and because, “The term suggested an innocuous curable condition to the casualty himself rather than frightening him with psychiatric terminology or making him think he suffered from some mental illness of a serious and disabling nature.”¹⁸ Authorities and psychiatrists were keen to avoid another “shell shock” epidemic. The “exhaustion” label allowed a soldier honourable escape from the battlefield while also suggesting his condition was transient instead of permanent, since “exhaustion” implied a state of weariness reversible by rest.¹⁹ The term also had the added bonus of preventing medical officers ignorant of battlefield psychiatry from mistakenly diagnosing soldiers suffering from other maladies as psychiatric cases.²⁰ Nevertheless, the recorded occurrence of malarial soldiers being accidentally labelled as neuropsychiatric cases demonstrated, among other things, that the multifarious nature of psychological trauma could easily be confused as something rather different by non-specialists.²¹

As with the First World War, it was difficult to appraise psychiatrists’ professional success during the Canadian campaigns of 1943 to 1945. In his retrospective survey of Canadian military psychiatry in the Mediterranean theatre A.M. Doyle, who served as a psychiatrist

¹⁶ Copp and McAndrew, *Battle Exhaustion*, 149-150.

¹⁷ A.M. Doyle, “The History and Development of Canadian Neuropsychiatric Service in the C.M.F.,” in Copp and Humphries, *Combat Stress*, 194.

¹⁸ Ibid.

¹⁹ As was also implied, this escape was only meant to be temporary.

²⁰ And it, in theory, prevented soldiers from self diagnosis, as had occurred with shell shock once the term entered popular parlance.

²¹ Ibid., 193.

attached to the 1 Canadian Division during the war, described his role as being one of a “traveler.” He saw few psychiatric casualties in the early stages of the Sicily campaign, but as fighting intensified on mainland Italy in December 1943 – during the same battles Mowat experienced – he recounted that in one twenty-four hour period he saw “57 patients and still did not keep abreast of the deluge.”²² Doyle, for his part, stuck to his guns that most cases were predisposed to neuropsychiatric disorder and “should have been weeded out as unfit for combat duty long before they got into action.”²³ Doyle’s view reflected beliefs in psychological predisposition and the need for more rigorous personnel screening, and was echoed in May 1943 by RCAMC District Psychiatrist Major D.G. McKerracher, who similarly opined that “experience has shown that these newly revealed psychiatric disorders invariably existed, at least potentially, before the individual was inducted into the army.”²⁴ Unlike numerous colleagues who by the war’s end arrived at a consensus that any man had his breaking point, whether “normal” or not, Doyle and McKerracher still believed that, “Most of our mistakes have been in the direction of trying to keep too many inadequate or neurotic people in positions of stress that they cannot endure.”²⁵

Also clear from Doyle’s account was that psychiatrists were still unwanted participants. He commented that although the Sicily campaign was dissatisfactory, he had “at least been ‘accepted’ when he was given command of a company of #9 Canadian Field Ambulance to take them on the assault upon Italy at Reggio.”²⁶ Many officers and physicians still felt psychiatrists allowed numerous men to shirk their duties using a “psychiatric escape hatch.”²⁷ It was only with

²² Ibid., 196.

²³ Ibid., 197.

²⁴ D.G. McKerracher, “Psychiatric Problems in the Army,” *Canadian Medical Association Journal* 48, no. 5 (1943): 399.

²⁵ A.M. Doyle, “The History and Development of Canadian Neuropsychiatric Service in the C.M.F.,” 220.

²⁶ Ibid., 192.

²⁷ Copp and McAndrew, *Battle Exhaustion*, 150.

the “especially traumatic time” in Normandy, during which the Canadians suffered exhaustion casualty rates as high as 30%, that psychiatrists were finally given respect by medical officers: “Like [Charles] Myers on the Somme in 1916, they suddenly found themselves in great demand, no longer the mocked pariahs of medicine. The doctors with 2nd Canadian Division, who before going to France had declared ‘We will have no psychiatric casualties’ and had refused to integrate the psychiatric service into the corps or divisional medical system, now rushed to offer the tiny psychiatric staff any help he could.”²⁸ Regardless of any perceived successes or failures, by 1945 specialists believed battle exhaustion often occurred in relation to the intensity of combat. Moreover, in spite of psychiatrists’ claims, early treatment close to the front and applied psychological pressure on a man to return to his unit also proved of little value in many cases.²⁹

One astonishingly frank description of the battle exhaustion experience was provided by Colonel F.H. van Nostrand, Great War veteran and the Canadian Army’s senior psychiatrist in 1942. In a paper given before the Inter Allied Conference on War Medicine at the Royal Society of Medicine in London on 9 July 1945, van Nostrand espoused, “There has probably been more muddled thinking and talking in connection with psychiatry than with any other branch of medicine ... Even the nomenclature of psychiatric disease has no uniformity, and many of the terms have no precise meaning, except to the persons using them ... [This] was a definite handicap in setting up a rational psychiatric service in the army.”³⁰ He made it clear that psychiatric advances made in the Second World War were better painted in terms of “lessons gained” rather than definitive conclusions.

²⁸ Shephard, *A War of Nerves*, 254.

²⁹ Copp, “From Neurasthenia to Post-Traumatic Stress Disorder,” 152.

³⁰ F.H. van Nostrand, “Neuropsychiatry in the Canadian Army (Overseas),” in Copp and Humphries, *Combat Stress*, 297.

Van Nostrand affirmed that the first three years of war taught psychiatrists that in 80% of psychiatric cases, there was “definite evidence of constitutional predisposition,” but, unlike many of his First World War counterparts, he also pointed out that the next largest group consisted of “soldiers of better type who break down because of the cumulative effect of the stresses of war.”³¹ Unfortunately, neither group was salvageable, because, “The first [group] ‘can’t take it’ and the second ‘have had it.’”³² Van Nostrand also expressed his belief in the futility of personnel selection systems, declaring, “We [psychiatrists] do not believe that any of the tests or batteries of tests now employed in testing recruits, accurately measure stability or the ability of the man to carry his anxieties without breakdown.”³³ Put simply, there was “no psychological breathalyser or litmus test.”³⁴

During his concluding remarks van Nostrand made another frank statement: “I am not convinced that psychiatry will ever solve the vast problem of the psychiatric breakdown of soldiers during war.”³⁵ His rationale displayed two dichotomies still irreconcilable in the twenty-first century: First, he saw a “direct conflict” between the needs of the military and the needs of the individual soldier as assessed by his physician; second, in essence the attitudes and behaviour of the “successful” soldier required a detached mindset at complete odds with all previous teachings about personal safety, destruction, and the taking of human life.³⁶ He finished with a plea “for the adoption of realistic attitudes toward the reactions of normal men and women to the stresses of war.”³⁷ In terms of unequivocal knowledge about psychological war trauma, the Second World War, like the war before it, ended with a whimper rather than a bang. By placing

³¹ Ibid., 299.

³² Ibid.

³³ Ibid., 300.

³⁴ Copp and McAndrew, *Battle Exhaustion*, 151.

³⁵ Van Nostrand, “Neuropsychiatry in the Canadian Army (Overseas),” 300.

³⁶ Ibid.

³⁷ Ibid.

emphasis on soldiers' life history and constitutional makeup, the 20% who had "had it" were still deemed the exception to the rule.

Medical Knowledge, Masculinity, and Pension Questions

The Canadian public was well aware of war's effect on soldiers' minds by 1939. Enough Canadians had seen shell-shocked veterans firsthand that by the Second World War the term and its evocative meaning were part of popular parlance. A 1940 *Globe and Mail* article discussing a downturn in the Saskatchewan wheat market stated that the situation could "be diagnosed as 'shell shock.'"³⁸ When the first hospital train brought eighty-nine Canadian war casualties to Toronto in August 1941, a reporter noted a "shell shock case" in the crowd, though it is unclear how they made that determination.³⁹ The public also took a great interest in the care of veterans suffering from psychological troubles, as evidenced by letters written to newspapers about the subject. One J.A. Kirkwood, expressing indignation at the conditions at Christie Street Veterans' Hospital in Toronto, wrote that it was a sad reflection on Canadian patriotism that German prisoners of war were kept "like tourists" in Muskoka, Ontario, while Canadians "shell shocked, [and] driven crazy with the awful sights they have seen and experienced" were lodged in a hospital no better "than a flophouse."⁴⁰ In another instance, Mrs. Jimmie Smith angrily described how the Army returned her son to combat despite his evident psychological difficulties. The young man was accidentally blown into the air on D-Day by Allied planes and saw his friends killed. He suffered from shell shock, but shortly after the event she received word "he was out of

³⁸ *The Globe and Mail*, 19 July 1940; Economists have been particularly fond of using psychological trauma and its labels to describe market events. One can see a similar use of this analogy even in the twenty-first century. After the events of 11 September 2001, a 3 November 2001 *Globe and Mail* article described the U.S. economy as suffering "a devastating bout of post-traumatic stress disorder."

³⁹ *Ibid.*, 4 August 1941.

⁴⁰ *Ibid.*, 16 August 1944.

the hospital and back in the lines.”⁴¹ She quoted a letter from the young man that mourned, “Mom, the way I feel right now, I will never be any good for army or civilian life.”⁴² Such letters reflected in part a shift in public attitudes regarding the care of wounded soldiers and veterans. Mothers, many whose husbands had fought through the First World War, and who had witnessed firsthand its effects on the numerous physically and psychologically affected veterans, were “no longer content meekly to take back their boys as shattered hopeless parcels dumped on their doorsteps” and instead often “demanded them back good as new.”⁴³

From the war’s beginning, Prime Minister Mackenzie King and the Liberal government were quick to address returning veterans’ needs. On the advice of Canadian Pension Commission Chairman Harold French, himself a Great War amputee, the King government established a committee on demobilization and rehabilitation in 1940 to create a program for returning veterans.⁴⁴ By December 1940, several subcommittees were exploring a number of salient issues, including “neuropsychiatric cases.”⁴⁵ Under what became the General Advisory Committee on Demobilization and Rehabilitation, the federal government broke from past practices, creating a system of rehabilitation benefits for everyone who served overseas (men and women inclusive).⁴⁶ Returning military personnel, cared for after 1944 by the newly created Department

⁴¹ Ibid., 18 November 1944.

⁴² Ibid.

⁴³ Shephard, *A War of Nerves*, 271-272.

⁴⁴ Neary, *On to Civvy Street*, 63.

⁴⁵ Ibid., 66.

⁴⁶ During the Great War, the federal government attempted to keep responsibility for unemployed veterans at the local level, under the belief that a national relief system would promote idleness and dependence. After the war the only universal benefit was a gratuity, which was deemed expensive and wasteful. Even King himself viewed the payments as having “encouraged undue periods of idleness.” The government wished to avoid a similar mistake by directing funds toward encouraging immediate rehabilitation and employment. See *ibid.*, 77 and 82; It is important to note that women were included in postwar plans in recognition of thousands of women’s direct and indirect contributions to the war effort during both world wars. In the Second World War, their service was exemplified in women’s enlistment in the Women’s Auxiliary Air Force, the Canadian Women’s Army Corps, and the Women’s Royal Canadian Naval Service. It is also important to note that contemporary gender norms and beliefs led to women’s pension scale being two-thirds that of men. For more on the subject see Neary, *On to Civvy Street*, 111-116.

of Veterans Affairs (DVA), were provided with a range of statutes, orders, and regulations, all of which came to be known in 1945 and after as the Veterans Charter.⁴⁷

Measures included, among other things, a year's free medical care following discharge, student loans, and training courses for ex-service women.⁴⁸ There were many long-reaching effects, such as a rise in university enrollment, a new understanding and treatment of disability, and the creation of "big government." Nevertheless, while the Veterans Charter was a "nation building experience," it was like all social programs a product of its time and place. The Charter and principles behind it were still rooted in traditional attitudes that deemed a strong work ethic, ambition, and independent financial means the goals of every proper man.⁴⁹ The program made a break with the past in much of its practice, but the ideology behind it was essentially conservative. The Charter's goal was above all else to utilize short-term programs and costs to prevent veterans' long-term dependency on the state.⁵⁰ As with the interwar period, psychologically injured veterans unable to work or retain employment were once again deemed undeserving of pensions.

After the war psychiatrists repeated their advice about granting pensions to "neurotic" veterans. Despite the profession's skepticism toward personnel selection systems and admittedly chastened knowledge of war neuroses, those deemed experts nonetheless felt certain enough in their theories to deny mentally ill veterans compensation using a similar justification as their

⁴⁷ Ibid, 162; The latter name originated in a July 1944 Finance memorandum. The Department of Veterans Affairs took over from the Department of Pensions and National Health.

⁴⁸ Ibid., passim; Women's courses still had a very gendered flavour to them, focusing on traditional women's employment such as hairdressing and dressmaking, but the encouragement to continued employment was nonetheless groundbreaking in its own right. See *ibid*, 216; Neary viewed the year's free medical care as a "prelude to medicare."

⁴⁹ Ibid., 284.

⁵⁰ Ibid., 86.

interwar counterparts.⁵¹ In Canada, care of neurotic veterans was given to the DVA. In turn, the DVA's Division of Treatment Services appointed Dr. Travis Dancey as adviser in psychiatry, making him one of the key officials behind DVA policy.⁵² Dancey began his career at the Verdun Protestant Hospital for the Insane in Montreal, served overseas at No. 1 Neurological Hospital, and later became head of the No. 1 Canadian Exhaustion Unit in late 1944.⁵³ In the final months of the war, he treated hundreds of battle exhaustion cases using physical therapies and hypnosis.⁵⁴

Notwithstanding his experimentation with physical therapies, Dancey was a firm adherent of the psychodynamic (life-history) approach to mental illness. As such, he subscribed to the concept of "secondary gain," something he defined à la Freud "the psychological and sociological advantages obtainable through being ill."⁵⁵ In a similar manner to Russel and numerous Great War physicians, Dancey and his Second World War colleagues saw pensions as detrimental to neurotic veterans' recovery. Psychiatrists believed neuroses stemmed from

⁵¹ Ironically, one of the purported advantages of IQ tests, personality profiling, and personnel selection systems in general was to cut down on the amount of postwar pensions by preventing the neurotic and "unfit" from making it into the armed forces. See Copp, "From Neurasthenia to Post-Traumatic Stress Disorder," 151.

⁵² Copp and Humphries, *Combat Stress*, 350.

⁵³ Although it is difficult to tangibly measure the postwar result, Copp highlighted that "dozens" of Canadian Army physicians were introduced to psychiatry through a short course run at Basingstoke. Copp argued that the Canadian neuropsychiatric hospitals and program were "a crucial episode in the development of the profession of psychiatry in Canada." See Copp, "The Development of Neuropsychiatry in the Canadian Army," 81.

⁵⁴ The use of hypnosis seems to have been a source of embarrassment for military authorities, probably on account of its association with pseudoscience and the occult, as well as hypnosis often being a staple plot device in numerous Hollywood horror films of the 1930s and 1940s. When writing of the history of Canadian neuropsychiatry during the war A.M. Doyle noted how several war correspondents published newspaper articles about the use of hypnosis. He wrote that, "Some higher authorities were upset about this," but it is unclear who he was referring to. See A.M. Doyle, "The History and Development of Canadian Neuropsychiatric Service in the C.M.F.," 195; For one such example of those articles see *The Globe and Mail*, 24 August 1943; Jones and Wessely highlighted that one British physician in the First World War eschewed hypnotism because it "conveyed a sense of occult power in the doctor." See Jones and Wessely, *Shell Shock to PTSD*, 27.

⁵⁵ T.E. Dancey and G.J. Sarwer-Foner, "The problem of the Secondary Gain Patient in Medical Practice," *Canadian Medical Association Journal* 77, no. 1 (1957): 1108; Concisely stated, psychodynamic understandings of mental illness "saw illness vertically rather than cross-sectionally: trying to understand the patient's problems of a given moment in the context of his or her lifetime history." See Shorter, *A History of Psychiatry*, 99; According to Copp and McAndrew Canadian psychiatrists showed little passion for Freudian theory, though it seems to have coloured much of their ideas and practice nonetheless.

childhood and upbringing, *not* from war trauma. Thus any anxieties from the latter were expected to disappear with time. If symptoms persisted, a physician need only look to how the trauma symptoms were utilized to cover up the ostensibly original traumas from early life. It is worth quoting at length Dancey's comparison between neurosis and physical illness to understand how he conceptualized the physician's role in pension questions. In 1957, Dancey and a colleague, G.J. Sarwer-Foner, both employed at Queen Mary Veterans Hospital in Montreal, wrote an article for the *Canadian Medical Association Journal* that discussed the persistent problem of the "secondary gain patient."⁵⁶ With regard to pensions, by then a widely discussed subject in the civilian context as well, the authors unequivocally stated the unique character of the pension issue as it related to the neurosis patient:

One might say that the subject of a neurosis is looked upon in a different way from other sick people. This may be true, but physicians should not be guilty of assisting the patient to remain ill through the payment of a monthly sum of money. It may well be that some people are penalized by this policy, but it must be kept in mind that this over-all policy is much more productive of good mental health than the opposite scheme would be.⁵⁷

Dancey and Sarwer-Foner's rather utilitarian approach was self-evident. In the battle between patient and physician, the latter must always prevail, even if his Hippocratic tendencies urged him otherwise. Some patients might be harmed by this approach, they acknowledged, but most would benefit, and the alternative – dependence, unemployment, and continued sickness – was far worse. Their view was not a radical one, having been elucidated by others before, during, and after the interwar period. Abram Kardiner stated in 1941 that, "The demand for and the dependency upon compensation is an essential and unconsciously determined defense mechanism and cannot be considered a prime factor [in secondary gain], although it is often an

⁵⁶ Dancey and Sarwer-Foner were Director of Psychiatry and Consultant in Psychiatry respectively.

⁵⁷ Ibid., 1110.

obstinate source of resistance in treatment and rehabilitation.”⁵⁸ Throughout the postwar years, Dancey compiled Great War psychiatric research conducted in the same vein to reinforce his position. He also consulted and engaged in correspondence with those of a like mind, including Dr. J.P.S. Cathcart, Chief Neuropsychiatrist of the DVA.⁵⁹ Their view of neurosis pensions fit well with a conservative government program, i.e. the Veterans Charter, which had the ultimate aim of encouraging work and reducing veterans’ dependency on the state. For all of their good intentions, Dancey and Sarwer-Foner’s characterization of neuroses placed a medically-endorsed stamp on any denial of compensation for those suffering from chronic war trauma.

Dancey and his colleagues’ view was more striking because it went against increasing evidence of cases involving “normal” men who suffered from war trauma and did not recover with time, as expected. In an August 1947 *Canadian Medical Association Journal* article, Major R.M. Billings, Captain F.C.R. Chalke, and Captain L. Shortt, all from the Royal Canadian Army Medical Corps, published a follow-up study of fifty-five veterans diagnosed with battle exhaustion during the war.⁶⁰ They discovered that even six months after being discharged, the men reported a wide range of persistent maladies, including: “nervousness and restlessness;” “depression, hostility, seclusiveness, shyness;” “battle dreams;” “startle reaction;” “insomnia;” and “psychosomatic disturbances.”⁶¹ Their study bore out the impression that “psychiatric disturbances precipitated by the severe mental trauma of warfare are not entirely benign, and that

⁵⁸ Kardiner, *The Traumatic Neuroses of War*, 70; The connection between compensation and continued illness was a thorny issue even prior to Freud’s conceptualizations of it in the 1910s, having been debated in the nineteenth century, particularly with the rise of litigation related to industrial and railway accidents. Erichsen wrote in 1866 that physicians were fast becoming the go-to experts in such litigation because “actions for damages for injuries alleged to have been sustained in railway collisions” had become “a very important part of medico-legal inquiry.” He lamented that “no little discrepancy of opinion has arisen as to the ultimate result of the case, the permanence of the symptoms, and the curability or not of the patient.” See Erichsen, *On Railway Injuries*, 44.

⁵⁹ Copp and Humphries, *Combat Stress*, 344.

⁶⁰ This article was highlighted in *The Globe and Mail*, 7 August 1947.

⁶¹ R.M. Billings, F.C.R. Chalke, and L. Shortt, “Battle Exhaustion – A Follow-Up Study,” *Canadian Medical Association Journal* 57, no. 2 (1947): 153; Most of the men included in the study had taken part in the invasion of Normandy on D-Day or joined the fight soon after.

physical and mental symptoms persist into civilian life.”⁶² In what turned out to be a prescient inference, they surmised they were “dealing with men whose difficulties and treatment-needs were increasing rather than decreasing, difficulties which may have future social implications, and treatment-needs which will have to be met eventually.”⁶³ Indicative of the social climate and stigma toward mental illness was the fact that only 25% of those deemed in need of treatment had sought medical advice by the time of follow-up.⁶⁴ Up until the 1960s, most mental health services were provided in large, custodial, overcrowded psychiatric hospitals. That situation did little to foster positive views toward mental illness or discussions of psychological difficulties.⁶⁵ Moreover, despite the commonplace nature of battle exhaustion diagnoses in the later war years, a *laissez-faire* attitude toward the socio-economic order encouraged veterans to fight through problems and avoid dependency on the government.⁶⁶

Thus after 1945 an “uneasy compromise between psychodynamic doctrine and the empirical evidence of veterans suffering from war-related chronic neurosis” developed in Canada.⁶⁷ The original post-1945 program for demobilizing veterans was supposed to include treatment only for conditions that arose up to one year after service. Nevertheless, the persistence of war-related neuroses among some veterans, and the delayed manifestation of others, forced the DVA to consider other approaches.⁶⁸ Hence, while Dancey and Canadian Pension

⁶² Ibid., 154.

⁶³ Ibid.

⁶⁴ Ibid.

⁶⁵ Donald Wasylenki, “The Paradigm Shift from Institution to Community,” in *Psychiatry in Canada: 50 Years (1951 to 2001)*, ed., Quentin Rae-Grant (Ottawa: Canadian Psychiatric Association, 2001), 51.

⁶⁶ Neary, *On to Civvy Street*, passim.

⁶⁷ Copp, “From Neurasthenia to Post-Traumatic Stress Disorder,” 154.

⁶⁸ It should be noted at this stage that the Canadian Pension Commission also took the approach that neuroses had their roots in childhood. Dancey outlined the details of the original post 1946 treatment plan for veterans: “At the expiration of this period [one year after service] he may receive treatment for his pensionable condition or for certain acute illnesses provided only that he has had meritorious service and provided he is relatively indigent.” He went on to write that, “This would mean that the thrifty veteran with a neurosis could not obtain treatment.” See Travis E. Dancey, “Treatment in the Absence of Pensioning for Psychoneurotic Symptoms,” in Copp and Humphries, *Combat Stress*, 344; It is clear that the DVA was recognizing “psychiatric disabilities” immediately

Commission officials work to ensure their compensation was minimal, the eventual alternative for chronic neurosis patients was hospital and therapeutic treatments. After consulting a 1943 American Psychiatric Association (APA) report on pensions and considering “those methods employed in other [presumably Commonwealth] countries,” the DVA decided to offer treatment to any veteran with a neurosis “regardless of his time or place of service or of his income provided it was felt that his symptoms could be expected to fade after a brief period of therapy.”⁶⁹ That program, which included the option of outpatient treatment, provided, among other things, the first clue that psychiatry was possible outside of the mental hospital.⁷⁰ Dancey and his colleagues were nonetheless careful to ensure that “dangers inherent in other schemes” were prevented, which meant “no financial allowances were permitted either to the patient or to his family.”⁷¹ Dancey was characteristically blunt: “Although this may create hardships, it does minimize any desire that a veteran may have to remain more or less permanently in hospital.” An added outcome of that approach created “a state of affairs where his family will urge him to return to work as soon as possible.”⁷² Chronic “neurotics” were encouraged to seek treatment instead of pensions. Simultaneously, a socio-economic milieu developed which prodded those outside the hospital to return to their prescribed, manly duties as family breadwinners.

At a 1950 meeting of the APA, Dancey discussed the ostensible successes of the DVA’s modified program. He declared that 420 veterans had received treatment under the new “classification” from 1 January 1948 to 31 December 1949.⁷³ That number corresponded to roughly 20% of all general hospital psychiatric cases under treatment at the time. He affirmed

after the war though. The DVA listed 641 men as having “psychiatric disabilities” in 1947, though it is unclear who fell under this category. See Neary, *On to Civvy Street*, 235.

⁶⁹ Dancey, “Treatment in the Absence of Pensions” in Copp and Humphries, 345; This program included both hospital and outpatient treatment.

⁷⁰ Healy, *The Creation of Psychopharmacology*, 28-29.

⁷¹ Dancey, “Treatment in the Absence of Pensions,” 345.

⁷² Ibid.

⁷³ Ibid.

that DVA district psychiatrists held the opinion that a “definite benefit” was noticeable in approximately 75% of cases. In a testament to the prevailing and enduring spirit of a pull-up-your-bootstraps work ethic, one of the main criteria for judging treatment success was the patient’s ability to return to work; the other was the patient remaining symptom-free for three months to one year.⁷⁴ As an example of the work being undertaken, Dancey reported on the Montreal system. At Queen Mary Veterans Hospital, a group of resident physicians enrolled in the McGill psychiatry course and other, part-time psychiatrists (who held private practices) utilized “analytically oriented psychotherapy” as the chief treatment method. In line with current practices, they also utilized “aids” such as insulin therapy and “diversional therapy,” the goal of the latter being to ensure every patient was fully occupied during hospital waking hours.⁷⁵ In 1946 Veterans Minister Ian Mackenzie boasted that Ste. Anne’s Hospital, also in Montreal, had good reason to hope for a 75% success rate treating “psychotics” using “electric shock therapy and insulin and sub-insulin shock.” Mackenzie noted the same treatments were also effective for neurotics.⁷⁶

A March 1947 *Globe and Mail* article on neurosis therapy at Westminster Hospital in London, Ontario provided a more complete picture of what the DVA program entailed.⁷⁷ There doctors focused on promoting “Self,” “Job,” “Home,” “Friends,” and “Religion” to a group of “young victims of neurosis” and other psychologically troubled veterans.⁷⁸ Westminster

⁷⁴ Ibid; One cannot help but notice the psychodynamic understanding inherent in this view. Since the illness was deemed to stem from unconscious factors and earlier life events, physicians saw a patient’s lack of symptoms as progress in working through their internal conflicts and an increase in their “ability” to remain symptom free. Such a view seems to have sometimes confused spontaneous (or otherwise) remission with patients’ willpower and “ability” to make their mind healthy.

⁷⁵ Ibid., 346; Dancey did not elaborate on what the diversions consisted of, though one can infer based on contemporary mental hospital care that they were akin to recreation and other stress-free activities. One cannot help but notice a hint of nineteenth century “moral” therapy in that approach. For a description of group psychotherapy conducted at Queen Mary Veterans Hospital see *The Globe and Mail*, 14 January 1952.

⁷⁶ *The Globe and Mail*, 23 March 1946; Ste. Anne’s was a DVA administered hospital.

⁷⁷ Westminster was likewise a DVA hospital.

⁷⁸ *The Globe and Mail*, 17 March 1947.

provided care to 700 veterans of both world wars who suffered from “neurosis” or “psychosis,” and the article glowingly reported that treatment consisted of “much more than drugs and psychotherapy.” Patients were divided into three groups: neurosis patients, “parole” patients (patients who had suffered from psychosis but were deemed to be “cured of a psychosis sufficiently”), and a third group of “psychotic patients” in closed wards under orderly supervision. The article’s author noted the presence of grand pianos in multiple sun rooms and patients’ artwork hanging on the walls. Patients also benefitted from “OT” (occupational therapy) shops, where they worked at hand looms, carpenters’ benches, and potters’ wheels. Their tooled leather was so well crafted that it apparently aroused “the acquisitive instincts of feminine visitors.”⁷⁹ In addition, a significant degree of co-operation with the University of Western Ontario allowed patients to tour the university’s observatory, natural science collection, and museum. The author reported that during the previous Christmas season 450 men from both closed and open hospital wards had been treated to a university Follies production. He happily concluded “there wasn’t a single ‘incident.’”⁸⁰

It is difficult for historians to appraise the relative success or failure of the DVA approach in terms of veterans “cured,” though it was evident that at least some remained ill and did not seek hospital treatment. Most men simply carried on as best they could, with many using the timeless method of alcohol intoxication to rationalize or cope with troubling memories. Many decades later a World War Two veteran at Sunnybrook hospital in Toronto stated that, “You were viewed as weak if you couldn’t handle it ... In the culture of the time, you didn’t talk about it.”⁸¹ For his part Dancey confidently claimed there was a “universal opinion” among district

⁷⁹ There were evident gender assumptions and stereotypes inherent in that comment.

⁸⁰ Ibid.

⁸¹ *The Toronto Star*, 7 November 2009; This was of course true of all mental illnesses during that time, and is arguably still the case.

psychiatrists that the modified program for neurotic veterans should be preserved, with minor alterations.⁸² He concluded by pointing to the “wider ramifications” of the pension question, particularly since the veterans’ pension program was part of a “rapidly developing interest” in social security for the non-veteran “man in industry.”⁸³ Regardless of Dancey and his colleagues’ view of the compensation question, pressure from veterans across the country unresponsive to the offered treatments slowly eroded psychiatrists’ ability to completely prevent pension-granting.⁸⁴ Moreover, the Assessment and Rehabilitation Unit of the DVA, the unit through which neurosis pensions were granted, allowed a “backdoor route” for those who had been denied compensation by the Canadian Pension Commission. Dancey was unequivocal in his opposition to a secondary route for troubled veterans. He affirmed the only reason that that route was not heavily utilized was due to limited publicity and the complexity of the appeal process.⁸⁵

Dancey continued writing even in 1970 to campaign against pensions for what he then termed “socio-psychological disability.” Again pointing to war veterans, he deplored the conditions whereby pensioners avoided work and forced their spouse to earn in order to keep their meager pension. The result was detrimental to the family because, “The husband then does the housework and there is a significant degree of reversal of role, with its deleterious results.”⁸⁶ With more than a hint of paternalism, Dancey cautioned against blaming the veteran, contending that a pensioned veteran was to be viewed as “a victim of circumstances and perhaps rather

⁸² Dancey, “Treatment in the Absence of Pensions,” 345.

⁸³ Ibid., 347.

⁸⁴ Copp and Humphries, *Combat Stress*, 351; One man, J.N.B. Crawford, Director of Treatment Services, Hong Kong veteran, and a former prisoner of war, felt so strongly about this stance that he even argued he too needed to avoid gratifying his own “dependency needs” with a pension, fearing it would cause him to lose his desire to work and avoid stressful situations. See *ibid.*

⁸⁵ Ibid; One has to wonder about the truth behind Dancey’s belief that a lack of publicity was a key reason why few veterans went that route, particularly given veteran’s mass participation in the Royal Canadian Legion, where rumours about such a route would have freely flown. Stigma seems like an equally likely candidate.

⁸⁶ Dancey, “The Interaction of the Welfare State and the Disabled,” *Canadian Medical Association Journal* 103, no. 3 (1970): 275.

fortunate in being able to obtain a marginal income, in spite of its emasculating qualities.”⁸⁷ The real problem in his estimation was the clinical physician, who was considered the “weakest link” and often demonstrated “sheer ignorance” of the patient’s “psychodynamics.”⁸⁸ For Dancey the pension issue was primarily a medical one, but his characterization of the interaction between illness and socio-economic questions was evidently influenced by contemporary gender norms. Thus the “uneasy compromise” between psychiatric doctrine and war-related neurosis persisted.

The DVA’s post-1945 reliance on psychiatrists, a relationship that expanded throughout the postwar years, represented “a more general trend ... in which the dictates of masculinity were medicalized.”⁸⁹ Although the federal government’s approach to psychologically injured veterans evolved during the 1918-1945 period, there was more continuity than change. The same “masculine codes” of self-reliance and stoicism expected of men in post 1918 society were also evident after the Second World War.⁹⁰ Pension-seeking was still construed as an “unmanly” activity, since pensions for war-related neuroses promoted dependence and prevented men from pursuing their ostensibly natural role as breadwinners. Psychiatrists like Dancey were absolute in their linking of idleness and illness. Men were deemed “better” or “cured” largely based on their attempt to return to their traditional role as manly, orderly breadwinners.

Hence there existed what cultural historian Christopher Dummitt called an “awkward overlap between the state’s emphasis on the ideals of liberal self-sufficiency and manly breadwinning” with regard to the treatment of disabled veterans, especially those with troubled minds.⁹¹ The federal government and psychiatrists’ goal was to literally and figuratively get men back to working condition. In Veterans Minister Mackenzie’s words, the aim was to return

⁸⁷ Ibid., 276.

⁸⁸ Ibid.

⁸⁹ Christopher Dummitt, *The Manly Modern*, 45-46.

⁹⁰ Humphries, “War’s Long Shadow,” 503.

⁹¹ Dummitt, *The Manly Modern*, 44.

neurotic war veterans to society “as normal, useful citizens.”⁹² Veterans’ mental state mattered only if it hindered gainful employment, a situation which disrupted the family unit and society.⁹³ Nevertheless, similar to their physically disabled counterparts, men traumatized by war felt entitled to compensation. Some in Canadian society agreed. In a 31 January 1948 *Globe and Mail* article, the author noted that although DVA physicians argued against pensions for neurotics, “some believe it [the policy] is obsolete and should be amended, [and] an ex-serviceman suffering from neurosis is entitled to [a] pension, just as if he had lost an arm.”⁹⁴ By denying the legitimacy of that claim the psychiatrist represented for many veterans the “worst agent of the modern state.”⁹⁵

Moreover, by diagnosing and describing veterans’ mental states, behaviour, and upbringing, psychiatrists “trod on the territory of manliness, secreting negative attitudes toward mental illness into this domain that the veterans considered sacrosanct.”⁹⁶ At a time when psychiatry was going through an “expansive period of professionalization” which extended the borders of medical “knowledge” into the socio-economic domain, psychiatrists’ explicit “medicalization of manhood” codified and reinforced masculine norms.⁹⁷ Put simply, to work was to be a proper man and be healthy; to be a pensioned neurotic was the inverse state of manliness and health, since it left a man primarily in the home and dependent – a naturally feminine state. There was little separation of medical knowledge and socio-economic norms. Like their First World War comrades, psychologically injured veterans of the Second World War faced an inherently unequal relationship with psychiatrists in both pension hearings and the

⁹² *The Globe and Mail*, 23 March 1946.

⁹³ Ibid.

⁹⁴ *The Globe and Mail*, 31 January 1948.

⁹⁵ Dummitt, *The Manly Modern*, 45.

⁹⁶ Ibid.

⁹⁷ Ibid., 46.

hospital. A psychiatrist's judgement of their mental state and behaviour affected not only pension eligibility, but a man's personal and home life as well. As demonstrated by Dummitt's research on Shaughnessy Hospital in Vancouver, the process was in and of itself painful and disturbing for many men. Their life history, behaviour, work ethic, and subjectively assessed manliness were all simultaneously placed on trial.⁹⁸

Korea

Just as 1918 brought about a dismantling of the psychiatric services created by militaries during the Great War, demobilization after 1945 caused "a rapid and remarkably complete collapse of the elaborate psychiatric system developed by the medical services of the Commonwealth armies."⁹⁹ Most psychiatrists, having served their country, were keen to quickly demobilize and resume interrupted careers.¹⁰⁰ Military psychiatrists returned to "an uncertain future," with prominent men obtaining university-affiliated hospital appointments and their less eminent colleagues resuming careers in provincial mental hospitals.¹⁰¹ The Army lost interest in psychiatry, and after 1945 the few psychiatrists who remained were once again placed in a screening role; an apparent act of amnesia regarding the lessons learned about its questionable effectiveness during the war.¹⁰² Consequently, when Canadians went to fight in the Korean War as part of British Commonwealth Forces Korea, their one forward psychiatrist initially represented the only psychiatric specialist in 1 Commonwealth Division.

⁹⁸ Ibid., 50.

⁹⁹ Copp and Humphries, *Combat Stress*, 349.

¹⁰⁰ Copp and McAndrew, *Battle Exhaustion*, 155.

¹⁰¹ Copp and Humphries, *Combat Stress*, 349.

¹⁰² Copp and McAndrew, *Battle Exhaustion*, 157.

As with the two World Wars, what began as a relatively lax policy on battle exhaustion gave way to a system resembling forward psychiatry in August 1951.¹⁰³ Psychiatric casualty rates, as in the Second World War, were worst during intense fighting or prolonged artillery bombardments.¹⁰⁴ For Canadians, due to the fact that many battles were “counted in hours rather than days or weeks” battle exhaustion was, according to Korean War historian Brent Byron Watson, “comparatively rare.”¹⁰⁵ In the “battle of Hill 355,” responsible for the largest proportion of neuropsychiatric casualties, battle exhaustion still accounted for less than 1% of total casualties incurred by 1 Royal Canadian Regiment.¹⁰⁶ Watson argued that, given the degree of deficiencies in training and equipment, it was “astonishing” more Canadian soldiers did not succumb to battle exhaustion throughout the conflict.¹⁰⁷

In most major respects, psychiatry during the Korean War was akin to the previous war, with battle exhaustion still the preferred diagnostic term, and one of the best therapeutic methods still considered motivation — namely the “expectancy” principle.¹⁰⁸ Mild cases were sent back to duty almost immediately, while more severe cases were evacuated to the field dressing station, sedated, and provided with short-term psychotherapy. The majority of exhaustion cases were eventually returned to their units, though more seriously affected soldiers were placed in support

¹⁰³ Copp and Humphries, *Combat Stress*, 349; Most cases were initially sent to Japan since there was little provision and no organized program for dealing with them.

¹⁰⁴ Edgar Jones, “Army Psychiatry in the Korean War: The Experience of 1 Commonwealth Division,” *Military Medicine* 165, no. 4 (2000): 257; Brent Byron Watson, *Far Eastern Tour: The Canadian Infantry in Korea, 1950-1953* (Montreal & Kingston: McGill-Queen’s University Press, 2007), 104.

¹⁰⁵ Watson, *Far Eastern Tour*, 104.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid., 107; The Canadians were not the only army that went to Korea unprepared. The Americans also hastily prepared and early in the war saw entire groups of men running for their lives. See Shephard, *A War of Nerves*, 341.

¹⁰⁸ Jones, “Army Psychiatry in the Korean War,” 258; Jones argued that F.C.R. Chalke’s appointment as an expert in personnel selection was an “attempt to stem the flow of evacuees.” This was a result of the fact that Canadian troops were hastily assembled and recruited as the Canadian military was relatively small and poorly prepared after five years of demobilization. Many soldiers were lost to chronic medical conditions or psychiatric problems within the first six months before the situation leveled off. In a few particularly egregious cases, a seventy-two-year-old man was signed up, as well as a man with an artificial leg. See *ibid.*, 257; Binneveld, *From Shell Shock to Combat Stress*, 129-130; Copp and McAndrew, *Battle Exhaustion*, 158.

units or sent back to Canada.¹⁰⁹ Upon their return from Korea, Canadian veterans with neuropsychiatric problems were provided with the same treatment programs as their World War Two comrades and encountered many of the same difficulties and dilemmas.

As the Cold War set in during the late 1940s and early 1950s, the Canadian government began a re-expansion of its defence capabilities. From 1949 to 1953 the number of Regulars increased from 47,000 to 104,000, and the Canadians established a long-term commitment to European defence against communist encroachment.¹¹⁰ Canadian military communities and bases remained in Germany for another forty years, with CFB Lahr in southern Germany being the last to close in August 1994. Nevertheless, after Korea, with the military's loss of interest in psychiatry and Canadian soldiers no longer engaged in large-scale combat, veterans' mental health discussions were once again relegated to psychiatric hospitals and beer halls.

The Spoils of War

While veterans' mental health was less of a prominent issue than it had been during and immediately after the two World Wars, psychiatric services were nonetheless on the rise. That trend reflected a burgeoning professionalization of Canadian psychiatry that began with the Great War. In their 1963 national appraisal of Canadian psychiatric services, the CMHA acknowledged the galvanizing effect the First World War had on psychiatry. Contrasting the prevalent pessimism toward the treatment of mental illness in the early twentieth century, they stated: "Realization that a rational and even scientific psychological treatment of mental illness was possible [sic] began only when the thousands of World War I shell shock casualties

¹⁰⁹ Watson, *Far Eastern Tour*, 105.

¹¹⁰ Ronald G. Haycock and Michael Hennessy, "The Road from Innocence: Canada and the Cold War, 1945 to 1963," in Bernd Horn, ed., *The Canadian Way of War: Serving the National Interest* (Toronto: Dundurn Press, 2006), 245.

demonstrated dramatically that everyone has his breaking point, everyone is vulnerable to psychological, social and physical stress.”¹¹¹ In the first decade of the twentieth century, psychiatrists were mainly found in asylums and had little respect among their medical colleagues, being considered “just a step, if that, above the spa-doctors and the homeopaths.”¹¹² After the Great War, psychiatrists and other mental health professionals, e.g. neurologists, became the de facto experts on shell shock and its myriad presentations. Their professional prestige rose accordingly. Historians have been somewhat more circumspect about the Great War’s legacy for Canadian psychiatry. Tom Brown pointed out that the Great War led to the beginning of psychiatry’s foray into purposes outside of its essential mission, and that the “Therapeutic State,” a system in which medicine and the state collaborated to control disapproved and deviant thoughts and actions, was “first forged in the crucible of the Great War.”¹¹³ The First World War instigated the spread of wartime psychiatric ideas into medical and civilian culture, and paved the way for psychiatrists to once again be called upon in the next war.

The Second World War and Canadian physicians’ experiences with battle exhaustion produced even more confidence amongst those in the Canadian psychiatric profession and were a key factor in its expansion after 1945.¹¹⁴ The succumbing of many soldiers to war-related traumas reified the idea that “mental-health problems could befall normal individuals,” thus setting the stage for the growth of the mental health industry.¹¹⁵ In his 2001 assessment of the postwar period, then editor of the *Canadian Journal of Psychiatry* (CJP) Quentin Rae-Grant

¹¹¹ J.S. Tyhurst et al., *More for the Mind: A Study of Psychiatric Services in Canada* (Toronto: Canadian Mental Health Association, 1963), 2.

¹¹² Shorter, *A History of Psychiatry*, 65.

¹¹³ Brown, “Shell Shock in the Canadian Expeditionary Force,” 324; The term “Therapeutic State” was coined by “antipsychiatrist” and author of *The Myth of Mental Illness* Thomas Szasz in 1963.

¹¹⁴ Copp, “The Development of Neuropsychiatry in the Canadian Army,” 67.

¹¹⁵ Arthur C. Houts, “Fifty Years of Psychiatric Nomenclature: Reflections on the 1943 War Department Technical Bulletin, Medical 203,” *Journal of Clinical Psychology* 56, no. 7 (2000): 940.

wrote that 1950 was “marked by an aura of optimism derived from the experience of the need for, and value and recognition of, psychiatry during World War II.”¹¹⁶ Psychiatric manifestations during World War Two were responsible for renewing interest in psychiatric disorders and treatments after decades of pessimism stemming from overcrowded asylums and few effective remedies for mental ailments.¹¹⁷ Numerous physicians who learned psychiatric theories and techniques during the war became eminent leaders in the post-1945 field. They brought their war experience into civilian practice, shaping Canadian psychiatry in the process.¹¹⁸

The Second World War’s impact on the mental health profession can be demonstrated simply by looking at the author list of *More for the Mind*. F.C.R. Chalke, Medical Officer during the war and postwar researcher on battle exhaustion, became the University of Ottawa Chair of the Department of Psychiatry, one of the Canadian Psychiatric Association’s founders (CPA), and editor of the *Canadian Psychiatric Association Journal* (now the CJP) from 1956 to 1972. John (Jack) D. Griffin was a colonel in the Canadian Army and worked under Brock Chisholm during the Second World War, later developing psychiatric rehabilitation programs for ex-service men and women, and among many other accomplishments, became General Director of the CMHA from 1951 to 1971. B.H. McNeel served as Officer Commanding 2 Canadian Corps Exhaustion Unit in Normandy. He was later appointed as adviser to the Deputy Director Medical Services, after the war writing of his experiences with battle exhaustion and becoming chief of the Mental Health Branch of the Ontario Department of Health.¹¹⁹ All three men had significant experience with wartime mental disorders, specifically battle exhaustion, during the Second

¹¹⁶ Quentin Rae-Grant, “Introduction,” in Quentin Rae-Grant, ed., *Psychiatry in Canada: 50 Years (1951 to 2001)* (Ottawa: Canadian Psychiatric Association, 2001), ix-x.

¹¹⁷ Cyril Greenland and Brian Hoffman, “Psychiatry in Canada from 1951 to 2001,” in Rae-Grant, *Psychiatry in Canada*, 1.

¹¹⁸ Ibid.

¹¹⁹ Among McNeel’s many interesting forays was a 1966 tour of medical facilities in the Soviet Union.

World War. They all went on to have long and influential careers in psychiatry and psychiatric policies after the war.

The war was also responsible for stimulating the CMHA's growth and the creation of distinctly Canadian psychiatric institutions, most notably the CPA. Until 1951 many Canadian psychiatrists were APA members, attending meetings south of the border, keeping up with developments through professional journals, letter correspondence, and face-to-face discussions at symposiums.¹²⁰ The postwar period and significant numbers of men affected by wartime experiences demonstrated the "magnitude of the psychiatric disorders facing veterans and their families after the war," Canada's relative unpreparedness, and psychiatrists' inability to lobby as a national body.¹²¹ Canadian psychiatrists also acknowledged that despite collegiality with their American neighbours, the APA could not influence the Canadian government. Consequently, intermittent discussions began in the mid-1940s to create a Canadian association, culminating in the 1951 establishment of the CPA.¹²² The CPA, along with the CMHA, henceforth became one of the leading Canadian institutions for encouraging public and government interest in psychiatric issues, and helped in establishing a professional identity for psychiatrists.

In 1950, the Canadian National Committee for Mental Hygiene became the Canadian Mental Health Association. Throughout that decade the CMHA developed provincial divisions and local branches across Canada. One of the CMHA's main goals was to increase public interest in mental illness and health. That task was accomplished largely through the development of volunteer programs in psychiatric hospitals, the creation of information and

¹²⁰ Occasionally APA meetings were held in Canada. There was a Section of Psychiatry in the Canadian Medical Association since 1945, but it had limited influence. More rarely Canadians went across the Atlantic to Britain to discuss ideas.

¹²¹ Werner Pankratz, "The History of the Canadian Psychiatric Association, 1951 to 2001," in Rae-Grant, *Psychiatry in Canada*, 29; Many Canadian provinces had (and still have) their own provincial organizations, but their affiliation was loose and lobbying power limited.

¹²² *Ibid*; The CPA started off as a relatively modest operation almost entirely run by volunteers for its first ten years, until a head office was created in Ottawa in 1961. See *ibid*, 44.

referral services, and consistent lobbying of the federal government on mental-illness related issues.¹²³ Concisely stated, “Scientific and professional opinion was marshalled in support of better methods of treatment and care.”¹²⁴ The CMHA also helped create a National Mental Health Research Fund. The Fund provided money for young researchers interested in mental illness and mental health, areas which hitherto received little funding or curiosity from medical students, in large part due to the low status attributed to psychiatrists by their peers.¹²⁵ The CMHA acknowledged that terms reflected a prevailing spirit of the times, and fought to have legal and public language changed, so as to abolish terms such as “idiot,” “imbecile,” and “lunatic.”¹²⁶ CMHA General Director John Griffin and his colleagues lamented that even the medical profession was often reluctant to accept mental illness as a group of diseases that deserved an investment of professional time, research, and money.¹²⁷

The CMHA’s efforts dovetailed with the 1948 National Health Grants Program introduced by the Mackenzie King government and Paul Martin Sr., Minister of National Health and Welfare. The program included, inter alia, a Mental Health Grant to aid provinces in developing and improving facilities for the mentally ill.¹²⁸ The great mobilization of medical and ancillary personnel into the Canadian Army during the Second World War created a situation whereby many overcrowded mental hospitals were greatly understaffed, leading to deteriorating conditions into the late 1940s.¹²⁹ The Mental Health Grant not only helped to reverse that trend, but over the next ten years fuelled the creation of new buildings, the opening of clinics, an

¹²³ Tyhurst et al., *More for the Mind*, 5-6.

¹²⁴ *Ibid.*, 6.

¹²⁵ Even in 1963 the authors of *More for the Mind* noted that one of the misconceptions still commonly held by Canadians was, “Psychiatrists are different from ‘real’ doctors in some undiscoverable way – they are not fully qualified as physicians or not to be trusted.” See *ibid.*, 9-10.

¹²⁶ Greenland and Hoffman, “Psychiatry in Canada,” 3.

¹²⁷ Tyhurst et al., *More for the Mind*, 12.

¹²⁸ Canadian Mental Health Association. “History of CMHA.” <http://www.cmha.ca/about-cmha/history-of-cmha/#.VNJ8CS5hwnM> (accessed January 27, 2014).

¹²⁹ Tyhurst et al., *More for the Mind*, 3.

increase in staff numbers, and according to Griffin et al., a “new professional interest in mental health and illness.”¹³⁰

The Second World War and war-related mental disorders nonetheless illuminated some of psychiatry’s most evident shortcomings, perhaps the best example being a lack of any standardized set of diagnostic criteria or definitions for mental disorders. Though psychiatrists devised names and rough symptom criteria for major psychiatric disorders like schizophrenia, combat created psychiatric manifestations quite different from the “insanity” experienced in asylums.¹³¹ Many affected soldiers were just “normal” men who had broken under the psychological strain of war.¹³² Before psychiatrists settled on “battle exhaustion,” as with the First World War, reactions to stress and anxiety were given many varying and idiosyncratic names.¹³³ During wartime, military hierarchies could impose a standardization of terms, e.g. battle exhaustion, but in a civilian milieu psychiatrists were free to use any terms they wished. Moreover, since most of the existing manuals were influenced by decades of asylum practice, a milieu where patients suffered from chronic mental illnesses like dementia and schizophrenia, they did not reflect what many patients presented after 1945.¹³⁴ Van Nostrand’s lament about the situation once again seemed accurate: “the nomenclature of psychiatric disease has no uniformity, and many of the terms have no precise meaning, except to the persons using them.”¹³⁵

¹³⁰ Ibid.

¹³¹ Shorter, *A History of Psychiatry*, 298.

¹³² Ibid; As Shorter pointed out, psychiatric classifications before the 1950s reflected the fact that most psychiatrists worked in mental hospitals. Since many of the hospitals were filled with those suffering from dementia and other chronic (and major) forms of mental illness, the naming systems reflected what psychiatrists saw and treated on a daily basis.

¹³³ Ibid.

¹³⁴ Shephard, *A War of Nerves*, 363.

¹³⁵ Van Nostrand, “Neuropsychiatry in the Canadian Army (Overseas),” 297.

The manifestations of trauma and other psychological disturbances, as well as a lack of any standard manual or system, resulted in a proliferation of terms and ideas that by the late 1940s amounted to “chaos.”¹³⁶ According to psychopharmacological researcher Thomas Ban, during the early postwar period there was “all kinds of nonsense” and “Everyone had his own little song.”¹³⁷ The American Psychiatric Association responded by creating a standard manual to bring order to the chaos. In 1948 a committee on naming laboured over an all-encompassing and national classificatory system, the result being the 1952 publication of the *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-I.¹³⁸ DSM-I was an evident example of how the Second World War influenced civilian psychiatry across North America: it was a modified form of the U.S. Army’s War Department Technical Bulletin, Medical 203 (Medical 203), created in 1943 by a committee chaired by Brigadier-General William C. Menninger, an influential psychiatrist serving in the Office of the Surgeon General.¹³⁹

Medical 203 codified much of the psychodynamic bent of numerous APA practitioners. Heavily influenced by Swiss-American psychiatrist Adolf Meyer, the first psychiatrist-in-chief of the Johns Hopkins Hospital in Baltimore, as well as Freudian theories, Medical 203 and DSM-I both characterized mental disorders as “reactions” of the individual in response to emotional states brought on by life events and circumstances.¹⁴⁰ Meyer, who coined the term

¹³⁶ Shorter, *A History of Psychiatry*, 298.

¹³⁷ Ban, Thomas. Interview by author. Toronto, May 1, 2014.

¹³⁸ Shorter, *A History of Psychiatry*, 298; DSM-I was also influenced in part by the work of Abram Kardiner.

¹³⁹ Arthur C. Houts, “Fifty Years of Psychiatric Nomenclature,” 937; William also founded, along with his father Charles and brother Karl, the famous Menninger Clinic in Topeka, Kansas in 1919. William and Karl were, according to Shephard, two of the “intellectual leaders” of American psychiatry. See Shephard, *A War of Nerves*, 203.

¹⁴⁰ Houts, “Fifty Years of Psychiatric Nomenclature,” 941; American psychoanalyst and historian Mitchell Wilson described this mixture of thought as “the theory of personality and intrapsychic conflict developed by Freud and the more pragmatic and environmentally oriented mental hygiene movement influenced by Meyerian psychobiology.” See Mitchell Wilson, “DSM-III and the Transformation of American Psychiatry: A History,” *American Journal of Psychiatry*, 150, no. 3 (1993): 400; It was Meyer who suggested using the term “mental hygiene.” For more on Meyer’s influence on American psychiatry see Susan Lamb, *Pathologist of the Mind: Adolf Meyer and the Origins of American Psychiatry* (Baltimore: Johns Hopkins University Press, 2014), *passim*.

“psychobiology” to describe his approach, emphasized the importance of researching all biological, psychological, and social events pertinent to a patient’s case history.¹⁴¹ Reflecting its Freudian-Meyerian spirit, Medical 203 saw combat exhaustion as “often transient in character” when promptly treated, but something which might progress into “one of the established neurotic reactions” if left unchecked.¹⁴² The authors viewed combat exhaustion as a predominantly transient phenomenon, thus making it a “temporary diagnosis” until a more “definitive diagnosis” - the “real” disorder related to the patient’s life-history - was established.¹⁴³ In DSM-I, combat exhaustion was replaced by “Gross Stress Reaction (GSR),” and categorized as one of the “Transient Situational Personality Disorders,” but DSM-I nonetheless copied almost word-for-word the language and characterization of Medical 203.¹⁴⁴ As with combat exhaustion, GSR was an appropriate diagnosis if the individual had been exposed to “severe physical demands or extreme emotional stress,” except DSM-I went a step further by stating this reaction could occur not only in combat, but also “in civilian catastrophe (Fire, Earthquake, Explosion, Etc.)”¹⁴⁵ The broadly conceived approach taken by both documents illuminated a shift in the “institutional geography” of North American psychiatry as more psychiatrists in the postwar period moved into private practice, and hospital and community psychiatrists brought with them a synthesis of Meyer and Freud’s ideas.¹⁴⁶ Although DSM-I was less widely read than the Manual’s future editions, it was an important document for enshrining psychiatry’s predominant approach for the

¹⁴¹ The “biopsychosocial” approach.

¹⁴² Office of the Surgeon General, Army Service Forces, “Nomenclature of Psychiatric Disorders and Reactions: War Department Technical Bulletin, Medical 203,” *Journal of Clinical Psychology* 2, no. 3 (1946): 289.

¹⁴³ Ibid.

¹⁴⁴ For example, while Medical 203 said that combat exhaustion occurred in “more or less ‘normal’ persons,” DSM-I similarly stated that Gross Stress Reaction occurred in “previously more or less ‘normal’ persons.” Even a superficial comparison between the two demonstrates the undeniable borrowing of the latter from the former.

¹⁴⁵ John Wilson, “The Historical Evolution of PTSD Diagnostic Criteria: From Freud to DSM-IV,” *Journal of Traumatic Stress* 7, no. 4 (1994): 688; That link was no doubt also due to the “traumatic neurosis” concept, which likewise characterized individual responses in civilian trauma in the same vein as those seen in war.

¹⁴⁶ Wilson, “DSM-III and the Transformation of American Psychiatry,” 400.

following few decades. While it is difficult to gauge the extent to which psychiatrists actually consulted DSM-I in their daily practice, the spread of the psychodynamic approach was apparent in a 1959-1960 survey by the American Group for the Advancement of Psychiatry (GAP), which reported that eighty-eight out of ninety-three U.S. and Canadian medical schools taught psychodynamics.¹⁴⁷

Between 1945 and the late 1960s, North American psychiatry, and in particular academic psychiatry, was also dominated by psychoanalysis, an approach popularized by the teachings of Freud and his followers. Psychoanalysis aimed at, among other things, finding the root of present psychological difficulties in childhood events.¹⁴⁸ Even at McGill University's Allan Memorial Institute, where the influence of biologically-oriented researchers like Heinz Lehmann and Ewen Cameron was pronounced, psychoanalysis was still represented, and according to Thomas Ban, the milieu was one where every type of psychiatric approach – including psychoanalysis – was represented.¹⁴⁹ That period, which Edward Shorter termed the “psychoanalytic hiatus” in psychiatry, was characterized by a brief era during the mid-twentieth century when “middle-class society became enraptured of the notion that psychological problems arose as a result of unconscious conflicts over long-past events, especially those of a sexual nature.”¹⁵⁰ Psychiatrists

¹⁴⁷ Gerald Grob, “Origins of DSM-I: A Study in Appearance and Reality,” *American Journal of Psychiatry* 148, no. 4 (1991): 429.

¹⁴⁸ Joel Paris, *The Fall of an Icon: Psychoanalysis and Academic Psychiatry* (Toronto: University of Toronto Press, 2005), 3; In Canada, with its feet in both European and American traditions, the spread of psychoanalysis was more intermittent than in the United States. With many British and European-trained psychiatrists in Canada, who adhered to a more biological approach, formal psychoanalysis was “relatively invisible” outside of large cities like Toronto and Montreal. In the west, for example, most psychiatrists during the postwar period still practiced in larger mental hospitals and according to Paris, “only a few” had an intense interest in psychotherapy. See Paris, “Canadian Psychiatry Across 5 Decades: From Clinical Inference to Evidence-Based Practice,” *Canadian Journal of Psychiatry* 45, no. 1 (2000): 35.

¹⁴⁹ Ban interview; In his *History of Psychoanalysis in Canada*, Alan Parkin saw this situation differently, stating that the establishment of the Canadian Psychoanalytic Society at McGill in 1955 was not “a sign of [Ewen] Cameron’s sympathy,” but a “matter of expedience to stem the loss of the residents from his post-graduate program in psychiatry to centres of Canada where training in psychoanalysis could be found.” See Parkin, *A History of Psychoanalysis in Canada* (Toronto: The Toronto Psychoanalytic Society, 1987), 84.

¹⁵⁰ Shorter, *A History of Psychiatry*, 145.

embraced this approach because it helped them to escape the dreary and stultifying nature of large mental hospitals, allowing them to seek community hospital employment or private practice opportunities.¹⁵¹ One effect of that movement was that for a few decades psychoanalysis and psychotherapy became synonymous, with psychiatrists at the forefront despite the fact that neither practice *necessarily* required medical expertise. Although there was some truth in Shorter's argument that the draw of medicalizing the psychoanalytic approach was that it helped psychiatrists to "exclude psychologists, psychiatric social workers, and other competitors from the newly discovered fountain of riches," their motivation went beyond financial matters.¹⁵² Psychoanalysis, with its ostensible ability to explain the mind's complexities and individual motivations, "filled a vacuum" that earlier heredity-based theories left after their dissipation.¹⁵³

In Canada, Brock Chisholm's rapid rise as Director General of Medical Service for the army in 1942 and appointment as the first Deputy Minister of Health in 1944 ensured that he disseminated the psychodynamic approach to a generation of Canadian psychiatrists both during and after the war.¹⁵⁴ Although Canadian psychiatrists were less influenced in the immediate postwar period by Freud and Meyer than their American colleagues, the psychodynamic influence on Canadian practitioners remained significant, particularly on those who went to war. Echoing Brock Chisholm's wartime speeches, in January 1947 John Griffin, Chisholm's consultant psychiatrist in wartime, told the Forest Hill Home and School Association in Toronto

¹⁵¹ A telling statistic about the number of psychiatrists who moved from hospitals to private practice was that by 1956 only about 17% of the roughly 10,000 members of the American Psychiatric Association (which included many Canadians) were employed in hospitals. This stood in stark contrast to 1940, when more than two-thirds of its members were employed in hospitals. See Grob, "Origins of DSM-I," 428.

¹⁵² Shorter, *A History of Psychiatry*, 146; Though Shorter's interpretation might seem harsh, even a more sympathetic account of the psychoanalytic movement stated that the expansion of psychiatrists into psychoanalytic territory was from an economic point of view "an imperialistic extension of psychoanalytic practice." See Nathan Hale Jr., *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917-1985* (New York: Oxford University Press, 1995), 274-275.

¹⁵³ Paris, "Canadian Psychiatry Across 5 Decades," 35; By extension it was believed psychoanalysis could explain societal motivations as well.

¹⁵⁴ Alan Parkin, *A History of Psychoanalysis in Canada*, 66-67.

that during the war “it was common to find vigorous, healthy young men who—as a result of inhibiting crippling dependence on their mothers—were incapable of participating in the defense of their country.” Once again stressing the importance of letting boys be boys, Griffin asserted that, “The over-solicitous parent and mother who pampers, dominates and controls her son interferes with his mature development into young manhood.”¹⁵⁵ Griffin believed parents must take their lesson from the Army and its capacity for instilling traditional masculine virtues when appraising human relationships.

Moreover, like Chisholm, Griffin affirmed that a boy whose “basic boyiness” was not lauded and encouraged by his mother would become laden with guilt, fear, and inferiorities, making him far less adaptable to difficult situations — e.g. wartime stresses — later in life.¹⁵⁶ B.H. McNeel, a co-author of *More for the Mind* and chief of the Mental Health Branch of the Ontario Department of Health in the 1960s, stated, like Chisholm and Griffin, that a possessive mother was “often a contributing factor” to her child’s mental difficulties.¹⁵⁷ Thus, influential Canadian psychiatrists utilized their war service and experience with war-related mental disorders as a confirmation that, in the words of gender historian Christopher Grieg, mothers converted “‘normal’ boys into emasculated boys who lacked the necessary amount of masculinity to engage successfully in military combat.”¹⁵⁸

In postwar Canada, men like Chisholm, Dancey, Griffin, and McNeel became defenders of traditional masculinity, and attempted to defeat gender anxieties brought on by altered postwar labour and gender relations. They used ostensibly objective psychiatric knowledge to reassert a traditional, “normal” masculinity prevalent earlier in the century. While during the war their

¹⁵⁵ *The Globe and Mail*, 22 January 1947.

¹⁵⁶ Greig, *Ontario Boys*, 18.

¹⁵⁷ *The Globe and Mail*, 9 May 1946.

¹⁵⁸ Greig, *Ontario Boys*, 18.

quest was largely confined to propping up anxious soldiers and reminding them of their duty to the country, after 1945 numerous physicians carried on that mission, becoming stalwart advocates of a return to a fearless and stoic masculine ideal. As they did with pension questions, psychiatrists utilized medical knowledge to affirm the legitimacy and primacy of their mission.¹⁵⁹ Boys, like their fathers, needed to be taught to be “rational, physically and emotionally self-controlled and disciplined, upright and moral, loyal, and obedient.”¹⁶⁰ Chisholm and others preached that such values had already been taught by the military. War had instructed them in the connection between prewar coddling and postwar neuroses that came not from the trauma of battle, but from faulty, effeminate parenting.

Psychiatrists returning from war brought with them novel ideas about treatment approaches. Those who saw battle exhaustion firsthand and, for better or worse, returned many psychologically affected soldiers to combat, believed that environmental stresses played a key role in mental illness. From that inference it was a short step to the belief that in a civilian setting early treatment outside of the asylum could also produce positive results.¹⁶¹ Given that most psychiatrists had trained and been employed in large mental hospitals before the war, where patients often languished for decades, the potential of early psychiatric treatment to head off chronic illness and eliminate the need for prolonged institutionalization was reason for optimism about the future.¹⁶² Put simply, “the success in returning to active duty servicemen who experienced psychological problems renewed a spirit of therapeutic optimism and activism, which was carried back into civilian life after the war.”¹⁶³

¹⁵⁹ Ibid., 121.

¹⁶⁰ Ibid., 122.

¹⁶¹ Grob, “Origins of DSM-I,” 427.

¹⁶² Ibid.

¹⁶³ Ibid.

In Canada, that confidence intersected with Chisholm and other influential psychiatrists' enterprise to "rouse the Canadian public to an awareness of the problems of mental health."¹⁶⁴ Just like GAP, formed under the stewardship of American Brigadier-General William Menninger in 1946, aimed to make psychiatry an important part of the postwar shaping of American society, Chisholm, his allies, and the CMHA in particular were keen to see social psychiatry at the vanguard of a new Canadian social order.¹⁶⁵ One of the CMHA's key aims was for mental illness to be "dealt with in precisely the same organizational, administrative and professional framework as physical illness."¹⁶⁶ The Association's successes throughout the early postwar period included the designation in 1951 of Mental Health Week during the first week of May each year. Local branches across the country used that week to raise awareness of mental illness through public visitation of mental hospitals, school poster and essay contests, and press articles.¹⁶⁷ Amidst great socio-economic changes over the next few decades, the Canadian psychiatric profession remained deeply involved in treating mental illness in the community and local hospitals, as well as spearheading campaigns to de-stigmatize mental illness and gain a foothold for psychiatric services in publicly-funded health insurance legislation. Thus while Griffin and his *More for the Mind* co-authors lamented in 1963 that the federal *Hospital Insurance and Diagnostic Services Act* of 1957 specifically excluded mental hospital patients from the benefits given to psychiatric patients in general hospitals, several years later they saw the fruits of their labour enshrined in

¹⁶⁴ Parkin, *A History of Psychoanalysis in Canada*, 71.

¹⁶⁵ Social psychiatry here means "psychiatry engaged in socio-economic issues and health policy." GAP was comprised of an abundance of prominent American psychiatrists, many of whom had served during the Second World War. This included the Menninger brothers, William and Karl, and Roy Grinker, among others. For more on GAP see Gerald Grob, "Psychiatry and Social Activism: The Politics of a Specialty in Postwar America," *Bulletin of the History of Medicine* 60, no. 4 (1986): 477-501; For a comprehensive overview of the many CMHA activities throughout the 1950s to 1980s, see Griffin, *In Search of Sanity*.

¹⁶⁶ Tyhurst et al., *More for the Mind*, 38; This became known colloquially as the "McNeel Ideal."

¹⁶⁷ Griffin, *In Search of Sanity*, 169.

the 1966 *Medical Care Act*, which provided funding for all psychiatric hospitals and did not discriminate between physical and mental illness.¹⁶⁸

Concurrently, as “social” psychiatrists strove to ensure a more equal treatment for mentally ill patients, and psychoanalysts in private practice treated less severe mental illnesses, in another important site – the laboratory – researchers were at work throughout the 1940s and 1950s on experiments to ameliorate and classify mental illness through drug-induced alteration of brain chemistry. During a time when, for example, Montreal’s Verdun Protestant Hospital had 1600 psychiatric patients and only a few physicians, researchers like Heinz Lehmann undertook experiments to mitigate the symptoms of major mental illnesses like schizophrenia.¹⁶⁹ Although most of those experiments came to naught, in 1953 Lehmann introduced a new antipsychotic drug – chlorpromazine – that had the seemingly miraculous effect of ameliorating the psychotic symptoms of chronic schizophrenia.¹⁷⁰ Lehmann quickly introduced English-speaking North America to chlorpromazine, and the result was the beginning of “the era of psychopharmacology.” That moment was “a turning point in the history of psychiatry.”¹⁷¹ Beyond the alleviation of psychotic symptoms in schizophrenia, depression, and mania, chlorpromazine and future drugs had the societal effect of accelerating deinstitutionalization – the downsizing or closing of large psychiatric hospitals across the country. Patients previously unable to live outside the walls of the hospital were often then free to live independently.¹⁷² On a professional level, biological psychiatry, an approach characterized by the idea that major psychiatric illnesses were the result of disordered brain chemistry and development, was given a

¹⁶⁸ Tyhurst et al., *More for the Mind*, 3; The *Medical Care Act* was implemented in 1968.

¹⁶⁹ Shorter, *A History of Psychiatry*, 247.

¹⁷⁰ For a more comprehensive history of chlorpromazine see Shorter, *A History of Psychiatry* 246-255 and Healy, *The Creation of Psychopharmacology*, passim; McGill University had the first division of psychopharmacology in the world.

¹⁷¹ Paris, “Canadian Psychiatry Across 5 Decades,” 35.

¹⁷² Ibid.

renewed confidence that slowly but eventually overtook psychoanalysis/psychodynamics as the dominant conceptualization and treatment of mental illness later in the century.¹⁷³

The 1960s became “the high-water mark of the psychoanalytic movement.”¹⁷⁴ At that time the most influential chairs of psychiatric departments across North America were trained psychoanalysts, and psychiatrists trained in analysis even began talking about treating major mental illnesses such as schizophrenia.¹⁷⁵ The spread of psychodynamic psychiatry and Freudian ideas could also be seen in the DSM’s second edition (DSM-II), released in 1968, which replaced most of the Meyerian “reactions” in DSM-I with Freudian “neuroses.”¹⁷⁶ As with DSM-I, the second edition characterized many disorders as the result of underlying psychological conflicts, and like its predecessor, the diagnostic criteria it provided remained vague.¹⁷⁷ DSM-II also made a significant break with its earlier edition in that Gross Stress Reaction, which had encapsulated psychiatrists’ experiences with war trauma, was eliminated, or seen another way, reclassified and placed under the umbrella term “Adjustment Reaction to Adult Life (ARTAL).”¹⁷⁸ Instead of a full analysis and description, the Manual provided just three short examples of ARTAL, one of which simply stated: “Fear associated with military combat and manifested by trembling, running and hiding.”¹⁷⁹ Such a simplistic description hardly scratched the surface of the multifarious symptoms seen by psychiatrists over the previous half century. The Manual’s appendices provided a list of other stressful events connected to it, e.g. railway

¹⁷³ Shorter, *A History of Psychiatry*, 239.

¹⁷⁴ *Ibid.*, 154.

¹⁷⁵ Paris, *The Fall of an Icon*, 3.

¹⁷⁶ Shorter, *A History of Psychiatry*, 299.

¹⁷⁷ *Ibid.*, 300.

¹⁷⁸ Wilson, “The Historical Evolution of PTSD Diagnostic Criteria,” 690.

¹⁷⁹ *Ibid.*; The other two examples were: “Resentment with depressive tone associated with an unwanted pregnancy and manifested by hostile complaints and suicidal gestures,” and “A Ganser syndrome associated with death sentence and manifested by incorrect but approximate answers to questions.”

accidents, but made no attempt to explain how the events specifically related to the symptoms.¹⁸⁰ Thus, DSM-II “contained no specific listing for a psychiatric disorder produced by combat.”¹⁸¹

Scholars interested in the DSM’s evolution have viewed the elimination of GSR from the Manual’s second edition in numerous ways. Psychologist John Wilson, who examined the historical evolution of PTSD diagnostic criteria across the twentieth century, opined that the simplicity and inadequacy of the examples used in DSM-II to describe ARTAL gave “pause to inquire as to why there was not a more adequate and complete delineation of the various types of trauma; their common effects on psychological functioning and the known clinical features associated with such stressful life experiences.”¹⁸² Perhaps even more puzzling, he noted, was why despite the occurrence of many traumatic events such as the Korean and Vietnam wars in the period between 1952 (publication of DSM-I) and 1968 (publication of DSM-II) GSR was not retained or enlarged. Ben Shephard explained this lacuna by noting that in the mid 1960s “few psychiatrists with first-hand experience of warfare were still around,” but there was evidently more to it than that. There were throughout the 1960s studies published in prominent journals such as the *American Journal of Psychiatry* and *Archives of General Psychiatry* on the persistence of “stress reaction” among combat veterans, so it was not true that psychiatrists were no longer aware of or disinterested in war trauma.¹⁸³

By 1965, when the DSM-II was in its planning and editing stages, American troops had already entered the Vietnam War. Their early experiences there from 1965 to 1967, when the rate of psychiatric breakdown among soldiers was only about five per 1000 troops – compared

¹⁸⁰ Ibid.

¹⁸¹ Scott, “PTSD in DSM-III,” 297.

¹⁸² Wilson, “The Historical Evolution of PTSD Diagnostic Criteria,” 691.

¹⁸³ For example, Herbert C. Archibald, Dorothy Long, Christine Miller and Read D. Tuddenham, “Gross Stress Reaction in Combat – A 15-Year Follow-Up,” *American Journal of Psychiatry* 119, no. 4 (1962): 317-322; Herbert C. Archibald and Read D. Tuddenham, “Persistent Stress Reaction After Combat: A 20-Year Follow-Up,” *Archives of General Psychiatry* 12, no. 5 (1965): 475-481.

with about fifty at the beginning of the Korean War – convinced military psychiatrists they “appeared to have licked the problem.”¹⁸⁴ Unlike during previous wars, the Americans immediately provided each battalion with medical personnel trained in psychiatric disorders and assigned psychiatrists to infantry divisions.¹⁸⁵ Shephard concisely summed up the situation: “There was [during Vietnam] military psychiatry from the start, not from the point where things began to go wrong.”¹⁸⁶ The Americans’ early implementation of forward psychiatry appeared to prevent an epidemic of psychiatric casualties, as had occurred at various points during the First and Second World Wars. Their ostensible success was confirmed by the 1970 book *Men, Stress, And Vietnam* by psychiatrist Peter Bourne, a team member of the Walter Reed Army Institute of Research and Vietnam veteran.¹⁸⁷ Bourne attributed the initially low rate of breakdown among American troops to empirically grounded ideas of war neurosis and the implementation of forward psychiatry.¹⁸⁸ Bourne was so confident in early successes that he espoused there was “reason to be optimistic that psychiatric casualties need never again become a major cause of attrition in the United States military in a combat zone.”¹⁸⁹ The lack of wartime experience among DSM-II editors combined with the early successful treatment of war neuroses in Vietnam to convince the Manual’s editors that there was no need to focus on or retain GSR.¹⁹⁰

The psychodynamic leaning of many practitioners was a likely factor in this decision. As with the Second World War, numerous psychiatrists believed Vietnam veterans haunted by their

¹⁸⁴ Scott, “PTSD in DSM-III,” 297.

¹⁸⁵ Ibid; As Shephard argued, by the end of the Second World War the Americans had become convinced that every man had his breaking point. See Shephard, *A War of Nerves*, 326.

¹⁸⁶ Ibid., 341.

¹⁸⁷ Peter Bourne, *Men, Stress, and Vietnam* (Boston: Little, Brown, 1970); Among other factors listed for the low rate of psychiatric breakdown were: one year tours of duty; short battles; few artillery barrages; and high morale. The twelve-month rotation of soldiers turned out to be a hindrance rather than a help. See Shephard, *A War of Nerves*, 348-349.

¹⁸⁸ Scott, “PTSD in DSM-III,” 296.

¹⁸⁹ Quoted in Shephard, *A War of Nerves*, 340.

¹⁹⁰ Scott, “PTSD in DSM-III,” 298; Scott pointed out that in a testament to clinicians and military psychiatrists simply adhering to whatever practice works best “in the field,” some psychiatrists still felt that GSR was useful and valid, and stuck to applying the concept in their work even after its removal from DSM-II.

war experiences suffered from a neurosis or psychosis that originated prior to combat.¹⁹¹ Despite decades of evidence to the contrary, they affirmed that any persistence of war-related psychological problems could be explained by underlying conflicts within the individual stemming from earlier life events. With years of distance since the Korean War's end in 1953 and Vietnam in the 1960s, during which time veterans' issues became less prominent, psychiatrists became convinced their model was accurate. But changes in the Vietnam War's course and an increasing number of veterans reporting psychiatric problems in the early 1970s coincided with sweeping changes in psychiatric research and thinking to set both psychiatry and trauma on a different trajectory by the end of the decade. Concisely stated:

More than any other war in the twentieth century, Vietnam redefined the social role of psychiatry and society's perception of mental health. Five years after the fall of Saigon, a new psychiatric term was devised, tailored to the needs of veterans. Psychiatric counselling was made available on an unparalleled scale, paid for by the United States government. Even more significantly, Vietnam helped to create a new 'consciousness of trauma' in Western society.¹⁹²

¹⁹¹ Ibid.

¹⁹² Shephard, *A War of Nerves*, 355.

CHAPTER 3: VIETNAM, TRAUMA, AND RECOGNITION

Perhaps wars weren't won any more. Maybe they went on forever.¹

Then ... the vets began to insist upon dealing with immediate psychological struggles, which were considerable, having to do with relationships to those around them, with their changing sense of masculinity, and with their conflicts with the society to which they returned.²

As the Vietnam War drew to a close, the rise of veterans' groups such as Vietnam Veterans Against the War (VVAW) reflected a troubled social milieu in the United States. Given the unpopularity of the war and the difficulties numerous veterans had readjusting to civilian life, war-related psychological problems once again became a subject of popular concern. Many soldiers abruptly returned alone from Vietnam by plane, instead of with their unit and by ship, as veterans of earlier wars had. That change in method gave returning men less time to mentally decompress and readjust to life as a civilian, and few or no comrades with whom to vent their experiences. Moreover, unlike their First and Second World War counterparts, troops returned home to find protests and civilian disgust at their participation, as well as difficulties finding employment.³ One key sign of trouble was the 30 April 1971 shooting death in Detroit of African-American Dwight 'Skip' Johnson, a Medal of Honour recipient killed by a grocery store owner during an attempted robbery.⁴

A three-part *New York Times* special series on Johnson a month later, covered simultaneously in Canada by the *Globe and Mail*, attempted to explain how "a Medal of Honor winner ended up dead in a holdup." Johnson, like myriad soldiers in many wars, was haunted at night by his wartime memories. He was especially troubled by the remembrance of a face-to-face encounter with a North Vietnamese soldier during which he shot the man at point-blank range

¹ Ernest Hemingway, *A Farewell to Arms* (New York: Scribner, 2003 [1929]), 118.

² Robert Jay Lifton, *Witness to an Extreme Century: A Memoir* (Toronto: Free Press, 2011), 187.

³ Shephard, *A War of Nerves*, 358.

⁴ *Ibid.*, 357; Shephard wrote that this event took place in Chicago in a liquor store, but Johnson was actually killed in Detroit, robbing a grocery/variety store.

and killed him, only managing to avoid death because the man's AK47 – drawn and ready before his – misfired.⁵ Stan Enders, a gunner in Johnson's tank on the morning of 14 January 1968 (fortune had placed Johnson away from his usual comrades in a different tank), recalled Johnson saving a friend from a burning tank. Unfortunately, Johnson was forced to watch the machine explode with the rest of his comrades inside after its artillery shells ignited within. Johnson, Enders remembered, “just sort of cracked up” and went into a berserker rage, hunting down all Vietnamese in the area with a pistol and sub-machine gun. He killed a number of them until running out of ammunition, and then used his machine gun stock to bludgeon another. When it was all over, Johnson, still in a rage, attempted to kill several Vietnamese prisoners rounded up after the battle. Enders recalled that it took “three men and three shots of morphine to hold Dwight down.”⁶ Johnson was taken away in a straitjacket and released from hospital the next day; his Vietnam tour was over. He was given the Medal of Honour for bravery by President Lyndon Johnson at the White House ten months later, in November 1968.

Conflicted about his wartime deeds, Johnson mostly kept silent about his tour. A friend recalled him being “all jumpy and nervous” and having to “be doing something all the time.”⁷ One of his cousins remembered him bringing back a series of coloured slides “of dead people.” A U.S. Army psychiatrist later wrote that Johnson suffered from “depression caused by post-Vietnam adjustment problem.”⁸ He became increasingly disillusioned about his heroism and the divided nation he returned to, and confided to his psychiatrist that he had recurring bad dreams and “entertained a lot of moral judgements as to what had happened at Dakto [the aforementioned battle].” Johnson also experienced guilt about his survival and wondered if he

⁵ *The Globe and Mail*, 27 May 1971.

⁶ Ibid.

⁷ Ibid.

⁸ *The Globe and Mail*, 28 May 1971.

was sane, asking his psychiatrist: “What would happen if I lost control of myself in Detroit and behaved the way I did in Vietnam?”⁹

Johnson was eventually committed to a U.S. Army hospital in Phoenixville, Pennsylvania, but after a short stay he used a three-day pass in March 1971 to abscond back to Detroit. The final year of his life was marked by increasing debts and isolation from others. On the evening of 30 April 1971, he visited his wife, who was in the hospital for removal of an infected cyst. Before leaving, he joked with her, asking if she was going to give him “a little kiss goodbye.” After leaving the hospital, he asked his family for a ride, claiming he needed to pick up money from someone who owed him. He rode with his mother, stepfather, and a friend to a predominantly white neighbourhood of Detroit, and asked them to stop. After leaving the car, he walked down the street out of sight. His family became nervous when thirty minutes went by without his return. At about 11:45pm, a police car appeared and two officers drew pistols on them, demanding to know the reason for their presence. After replying that they were waiting for Dwight Johnson, they were told by the officers that he was “[dead] on the floor of a grocery store around the corner.”¹⁰ His mother later wondered if “Skip tired of this life and needed someone else to pull the trigger.”¹¹

Johnson’s case was an extreme but nonetheless representative example of the importance of both medical and socio-economic concerns for returning soldiers. He returned traumatized and haunted by his wartime experiences; he also believed Vietnam had irrevocably changed him. His readjustment to civilian life was made more difficult by the fact that he returned home to a divided nation and could not square the heroism of his actions with the seeming senselessness of

⁹ *The Globe and Mail*, 29 May 1971.

¹⁰ Ibid.

¹¹ Ibid.

it all, particularly in light of the War's polarizing effect on American society.¹² Unlike soldiers of the First and Second World War, Johnson could cite no definitive cause to alleviate his guilt, nor could he necessarily expect a warm reception from civilians, despite the official praises he received. Johnson and his comrades "were not given victory parades and church services; did not receive absolution. Because the war seemed to them to have no meaning, the killing was doubly sinful."¹³ On a societal level, the shock of a Medal of Honour winner dying during a grocery store robbery, and the media coverage it received, put veterans' issues on the map and once again raised public consciousness of war-related trauma.¹⁴ Johnson's case was discussed in numerous newspapers and academic journals, and an off-Broadway play about his life was viewed around the United States and on television.¹⁵

Psychiatry, Politics, and the War that Never Ended

One year after Johnson's death, on 6 May 1972, *The New York Times* published an article about Vietnam veterans' troubles by Chaim Shatan, a radical psychiatrist and co-director of the psychoanalytic training clinic at New York University's Graduate Department of Psychology.¹⁶ Shatan's article was based on numerous veterans' "group rap" sessions he and his colleagues – all opponents of the war – had organized in New York, and the "commonly shared concerns" that emerged.¹⁷ The meetings began two years earlier in 1970 through the combined efforts of Shatan, VVAW president Jan Crumb, and Shatan's colleague Robert Jay Lifton, a former Korean

¹² For more on postwar Detroit and racial relations see Thomas Sugrue, *The Origins of the Urban Crisis: Race and Inequality in Postwar Detroit* (Princeton: Princeton University Press, 2005 [1996]).

¹³ Shephard, *A War of Nerves*, 372.

¹⁴ *Ibid.*, 357.

¹⁵ Scott, "PTSD in DSM-III," 300.

¹⁶ Shatan lived in Canada from the 1920s, obtaining his medical degree from McGill University. He moved to New York City in 1949.

¹⁷ *The New York Times* (New York), 6 May 1972.

War Air Force psychiatrist who wrote about survivors of the Hiroshima bombing.¹⁸ Crumb sought Shatan and Lifton because their careers “combined professional knowledge with antiwar advocacy.”¹⁹ Veterans attended the meetings because of a distrust of “establishment” psychiatric services, and also because their postwar disturbances “manifested themselves too late to prove the ‘service connection’ required for Veterans Administration [VA] treatment.” Shatan listed a number of basic themes revealed during the sessions, including: guilty feelings “for those killed and maimed on both sides;” feelings of being scape-goated and victimized, first by “inadequate” VA treatment and benefits, and then by society for using and betraying them; rage stemming from “the awareness of being duped and manipulated;” brutalization from being “chewed up in the Vietnam war machine” and “spit out unfeeling;” alienation from their feelings and other people; and doubt about their “continued ability to love others.”²⁰

Lifton noticed common effects among civilian and military trauma survivors, especially “intense expressions of psychic numbing.”²¹ In addition to numbing, there were also ongoing and spontaneous moments of terror. Shatan’s *Times* article cited individual cases of Vietnam veterans such as “Steve,” who eighteen months after discharge from Marine combat duty still suffered “unpredictable episodes of terror and disorientation,” even in familiar places like Times Square. Since the veterans’ shared concerns did not fit “any standard diagnostic label,” Shatan wrote that, “we refer to them loosely as the post-Vietnam syndrome.” The sum total effect of the syndrome was “impacted grief,” in which “an encapsulated, never-ending past deprives the present of

¹⁸ Lifton, *Witness to an Extreme Century*, 184-185; Lifton, *Death in Life: Survivors of Hiroshima* (Chapel Hill: University of North Carolina Press, 1991 [1968]); Lifton’s 2011 memoir is a captivating account of his work throughout the second half of the twentieth century.

¹⁹ *Ibid.*, 185; Lifton was opposed to the Vietnam War even before it began after a 1954 discussion with a group of Frenchmen in a Saigon café shortly after the battle of Dien Bien Phu. See *ibid.*, 167.

²⁰ *The New York Times*, 6 May 1972.

²¹ Lifton, *Witness to an Extreme Century*, 130.

meaning.”²² Those group sessions further revealed that numerous veterans were dealing not just with war trauma, but a “changing sense of masculinity.”²³ Session participants often discussed the “John Wayne thing,” and cited society’s emphasis on traditional “macho emotions,” feelings stoked by the military, and which often led to violent inclinations even once out of uniform.²⁴ Lifton recalled one particularly emotional session when a veteran described killing a Viet Cong soldier with a knife. The man expressed moral ambivalence about his actions, feeling sorry for killing another human being but failing to understand why, since it was in the line of duty, and “John Wayne never felt sorry.”²⁵ Such emotional quandaries reflected Vietnam veterans’ desire to achieve a moral equilibrium amidst conflicting feelings about their own bravery, masculinity, and sense of duty, all set against the backdrop of a deeply divided American society.

Like shell shock before it, post-Vietnam syndrome was an ambiguous but evocative term that metaphorically captured the troubles of many “lonely” soldiers, who, as during their time in Vietnam, were “unable to see their enemies” but nonetheless, felt anonymous and haunting threats.²⁶ The term also became “a frightening buzz word among clinicians and journalists” and a “thinly veiled position of opposition to the war.”²⁷ Despite the term’s use in popular discourse though, even within the Veterans Administration nomenclature for classifying and treating patients with war-related trauma remained largely idiosyncratic.²⁸ Shatan and his colleagues, especially Lifton, were also influenced by a growing literature about Holocaust survivors.²⁹ Along with veterans’ advocacy, psychiatric work with post-Holocaust and other “survivor”

²² *The New York Times*, 6 May 1972; Scott, “PTSD in DSM-III,” 300; Essentially, Shatan believed that the symptoms listed in his article stemmed from an “unconsummated grief” that soldiers were unable to exorcise on the battlefield. The apathy that developed as a result manifested itself in the symptoms presented at the rap sessions.

²³ Lifton, *Witness to an Extreme Century*, 187.

²⁴ *Ibid.*

²⁵ *Ibid.*, 189.

²⁶ Binneveld, *From Shell Shock to Combat Stress*, 41.

²⁷ Shephard, *A War of Nerves*, 359.

²⁸ Scott, “PTSD in DSM-III,” 299.

²⁹ Shephard, *A War of Nerves*, 360.

groups “created a new professional model: the psychiatrist as patients’ advocate, helping a group of wronged victims to win reparation. Their work also popularized the idea of a general, loosely-defined ‘syndrome’ among a group of patients, made the idea of delayed emotional after-effects of trauma respectable and put guilt, particularly survivor guilt, on the agenda.”³⁰ For critics of Shatan and his colleagues’ advocacy on behalf of veterans and other trauma victims, the key legacy of the new “syndrome” was that it created a shift in understandings of victimhood. The new term and its meaning placed much greater emphasis on victimhood than endurance, making even veterans who participated in atrocities victims of their own actions.³¹

By the mid-1970s, Shatan, Lifton, and VVAW were still fighting to persuade the APA to revise their nomenclature and acknowledge veterans’ psychiatric problems.³² Shatan was dismayed since the late 1960s about the disappearance of a combat-stress diagnosis in DSM-II, and his 1972 *Times* article was part of a long campaign to ensure that situation was reversed.³³ Robert Lifton for his part attacked American psychiatry (namely the APA) and military psychiatry, particularly the latter for the primacy it placed on conserving the fighting strength at the expense of the individual soldier.³⁴ Lifton and Shatan’s advocacy efforts also made them radical vis-à-vis their colleagues, with their vocal antiwar stance placing them outside the psychiatric mainstream. Lifton recalled in his 2011 memoir that “psychiatrists like Hy [Chaim] Shatan and myself were also experiencing war-related alienation from American society ... the rap groups, which functioned outside ordinary channels, were a product of this shared

³⁰ Ibid; Copp and Humphries argued that part of Lifton and Shatan’s quest to get a Vietnam syndrome recognized was based on a desire to use the disorder’s recognition as a further way to undermine the legitimacy of the war itself. Lifton’s 2011 memoir confirmed that view. See Copp and Humphries, *Combat Stress*, 415-416, and Lifton, *Witness to an Extreme Century*, 184-191.

³¹ Shephard, *A War of Nerves*, 360.

³² Ibid., 362.

³³ Scott, “PTSD in DSM-III,” 301.

³⁴ Ibid., 302.

alienation.”³⁵ After establishing links with the National Council of Churches and various universities and publication outlets across the United States, they helped to form the National Veterans Resource Project, a group created to convince mainstream psychiatrists and the APA to recognize post-Vietnam syndrome.³⁶

Fortuitously, the APA was simultaneously under attack by gay rights activists because of the inclusion of homosexuality as a “disorder” in DSM-II.³⁷ In December 1973, 20,000 APA psychiatrists voted on the heated issue, with 58% approving revisions to DSM-II.³⁸ Homosexuality was thus categorized as a “sexual orientation disturbance” instead of a “disorder,” and the Manual’s architects decided that homosexuality would only be considered a disorder if the individual in question experienced distressful feelings about their sexual orientation.³⁹ With just one referendum the APA reversed a century-old position on homosexuality. In the short term, the effect slightly decreased pressure on the APA, which was fighting several battles at once. The long-term effect was bluntly but accurately stated by Edward Shorter: “Once it became known how easily the APA’s Nomenclature Committee had given way on homosexuality, it was clear that the psychiatrists could be rolled.”⁴⁰ The homosexuality controversy demonstrated that socio-political pressure could be exerted on the APA to obtain the addition, alteration, or deletion of psychiatric syndromes from the DSM. Shatan and Lifton’s quest to gain mainstream psychiatric recognition for post-Vietnam syndrome fell in a similar pattern to the homosexuality controversy, and their well-intentioned efforts exposed that psychiatric classification was not a purely objective process.

³⁵ Lifton, *Witness to an Extreme Century*, 185.

³⁶ *Ibid.*, 303.

³⁷ Shorter, *A History of Psychiatry*, 301.

³⁸ This event received coverage in Canadian news circles. See *The Globe and Mail*, 17 December 1973.

³⁹ Scott, “PTSD in DSM-III,” 304. Those events were covered extensively by Ronald Bayer in *Homosexuality and American Psychiatry: The Politics of Diagnosis* (New York: Basic Books, 1981).

⁴⁰ Shorter, *A History of Psychiatry*, 304.

In June 1974 *Psychiatric News* reported that a new DSM – DSM-III – was in the works.⁴¹ Around that time, the head of the DSM-III task force, Robert Spitzer, during a phone conversation stated that “no change” was planned with regard to combat-stress disorders. Surprised and dismayed after hearing about Spitzer’s decision through word-of-mouth channels, Shatan and Lifton met with one another to discuss future plans.⁴² The decision was made to apply public pressure through a radio station in New York City. They arranged an all-day broadcast on Vietnam veterans, and were quite successful, encouraging listeners to phone in and discuss the issue.⁴³ Next, they arranged a meeting with Spitzer at the APA’s annual convention in 1975. At the convention, Spitzer challenged Shatan and his colleagues to disprove works arguing against the separate classification of Vietnam veterans’ problems. Shatan once again took the lead, and organized a working group to research the issue and gather evidence. The group came up with the term “post-combat disorder,” but as time went on, and after consulting Holocaust literature, the group began to conceptualize the syndrome they envisioned as a more general disorder affecting both civilian survivors and combatants.⁴⁴ Spitzer, still somewhat skeptical, nevertheless appointed a Committee on Reactive Disorders to proceed with research and report to the DSM-III task force. Spitzer gave the committee the assignment of working with Shatan and Lifton to justify and develop a diagnosis.⁴⁵

Shatan’s group received a significant intellectual boost when Mardi Horowitz joined the fight. Horowitz was a professor of psychiatry at the Langley Porter Neuropsychiatric Institute at the University of California, San Francisco, and was in the process of putting together a monograph on stress’ effects on the mind. The final product, his landmark 1976 book *Stress*

⁴¹ Scott, “PTSD in DSM-III,” 304.

⁴² Ibid.

⁴³ Ibid., 305.

⁴⁴ Ibid.

⁴⁵ Ibid.

Response Syndromes, produced an overarching theory of the cognitive and emotional responses to stress, particularly traumatic stress. In the monograph, he discussed the thorny nature of enduring stress-related psychological difficulties, stating: “The crucial issue concerns the existence, nature, and etiological [causal] importance of general stress response tendencies as contrasted with idiosyncratic or person-specific types of variation in response to stress.”⁴⁶ In spite of the evident difficulties in sorting cause from effect and general from specific, and the absence of something like Gross Stress Reaction in DSM-II, Horowitz nonetheless boldly predicted that DSM-III would “probably take cognizance of such issues as will be discussed here, and return a stress response entity to the official list of diagnoses.”⁴⁷ Horowitz’s work signalled a significant break from the past. He affirmed that with regard to long-term stress syndromes the issue of “how much is predisposition and how much is the effect of immediate stress is hard to elucidate because every syndrome will be composed of both sources of influence.”⁴⁸ Such statements indicated the intellectual ground was shifting, and that predisposition was no longer thought of as *the* deciding factor in the mind’s long-term response to abnormally stressful events.

Horowitz’s study was an amalgamation of theories and work by Freud, Kardiner and other World War Two authors, as well as Shatan and Lifton’s more recent work with Vietnam veterans and Hiroshima survivors.⁴⁹ He utilized the vast literature available and surmised that there were eight common responses to highly stressful events: Fear of repetition of the event; shame over helplessness or emptiness; rage at the source; guilt or shame over aggressive impulses; fear of “aggressivity” toward others; survivor guilt; fear of identification or merger

⁴⁶ Mardi J. Horowitz, *Stress Response Syndromes* (New York: Jason Aronson, Inc., 1976), 26.

⁴⁷ Ibid.

⁴⁸ Ibid., 28.

⁴⁹ He also cited and was influenced by Holocaust survivor literature.

with victims, that is assuming the self as victim, even when the reality was otherwise; and sadness in relation to loss of another person, or symbolically of “the self.”⁵⁰ Several of those responses later became enshrined as PTSD symptoms. Horowitz, who was a “tireless builder of intellectual structures,” built a bridge between civilian trauma in events like natural disasters, serious car accidents, or shipwrecks, and the trauma of combat soldiers.⁵¹ He also delineated a coherent framework for important factors in chronic stress syndromes, including the concept of “phases of stress response.” Horowitz used World War Two, Holocaust, and Vietnam veterans’ literature to demonstrate that although such events produced incredible strain there were, “phases of response in which denial or intrusive symptoms and signs may predominate.”⁵² There was thus provision within his system for delayed symptoms, which was observed in previous wars and their aftermath but most often attributed to character weakness or neurosis rather than the mind’s attempt to suppress traumatic memories. With Horowitz’s theories as a framework, Shatan’s vague concept of post-Vietnam Syndrome was henceforth given intellectual coherence and academic credence.⁵³

Although resistance continued for another few years, by 1978 Shatan and his colleagues gathered enough evidence to convince Spitzer and the other two members of the APA’s Committee on Reactive Disorders to call a meeting and review the findings. In January 1978, Spitzer and the Committee finally acquiesced. They recommended a diagnosis under the label “post traumatic stress disorder,” that appeared in the DSM’s third edition.⁵⁴ No longer, as in the past, would emotional distress after combat be lumped under standard psychiatric syndromes of depression, alcoholism, or schizophrenia, and considered a product of the individual’s

⁵⁰ Ibid., 23-24.

⁵¹ Shephard, *A War of Nerves*, 367.

⁵² Horowitz, *Stress Response Syndromes*, 41.

⁵³ Shephard, *A War of Nerves*, 367.

⁵⁴ Scott, “PTSD in DSM-III,” 307.

maladaptive capacities stemming from earlier life events.⁵⁵ Wilbur Scott deftly elucidated the socio-political nature of Shatan and his colleagues' campaign: "PTSD is in DSM-III because a core of psychiatrists and veterans worked consciously and deliberately for years to put it there. They ultimately succeeded because they were better organized, more politically active, and enjoyed more lucky breaks than their opposition."⁵⁶ Once again war proved a catalyst for altering psychiatric thought and practice.

The PTSD concept drew a decisive line in the sand, and was the first time the presumed cause and persistence of the disorder was relocated from the patient's life-history to the external trauma incurred during wartime (or for civilians during disasters or other traumatic events). The nomenclature was a key factor. "Post traumatic," meaning "after injury," made it clear that the disorder indicated a change in well-being *as a result of the trauma*, not because of emotional and psychological conflicts from earlier life, as was thought with neuroses.⁵⁷ The prime criterion for diagnosing PTSD was "the existence of a recognizable stressor [stressful event] that would evoke significant symptoms of distress in almost everyone."⁵⁸ That criterion was crucial because it acknowledged that a high magnitude of stress was enough to evoke psychological trauma in "almost everyone," making PTSD symptoms normal rather than aberrant manifestations of illness, even in the long term. Thus, the "uneasy compromise between [psychodynamic] doctrine and the empirical evidence of veterans suffering from war-related chronic neurosis" was finally shattered.⁵⁹ The APA's official recognition of PTSD was "a turning point, a major paradigm shift, in ideas about psychological trauma."⁶⁰ On a societal level, PTSD's enshrinement helped

⁵⁵ Ibid., 308.

⁵⁶ Ibid.

⁵⁷ Wilson, "The Historical Evolution of PTSD Diagnostic Criteria," 692.

⁵⁸ Ibid.

⁵⁹ Copp and Humphries, *Combat Stress*, 352.

⁶⁰ Ibid., 353.

legitimize long-term psychological difficulties in Vietnam veterans and other trauma sufferers, and at least in principle, made diagnosing trauma symptoms an objective matter.

Psychiatric Adventures

Crucially, while traumatic stress and its effects were re-formulated in the 1970s, another paradigm shift was in the making. The 1960s, which saw the high-water mark of the psychoanalytic movement, as encapsulated in DSM-II, also saw the nascent rise of “biological psychiatry.”⁶¹ Beginning in the late 1960s and early 1970s, a small group of dedicated researchers from Washington University, St. Louis, interested in brain chemistry, biology, and disease classification, formed a “counterrevolution” against psychoanalysis.⁶² Psychodynamic theorists were largely uninterested in the classification of mental disorders. On the other hand Robert Spitzer, head of the DSM-III task force, and the “St. Louis group,” sought to make psychiatric diagnosis as accurate as possible, in order to reflect what were presumed to be biologically-rooted diseases.⁶³ In 1972, John Feighner, a diagnostician at Washington University, and several colleagues, published what became known as the “Feighner criteria,” a list of diagnostic criteria for fourteen psychiatric illnesses.⁶⁴ As a testament to the intellectual shift occurring in psychiatry, Feighner’s paper was the most cited psychiatric paper throughout the

⁶¹ Edward Shorter termed this the “second biological psychiatry,” to differentiate it from the “first,” which occurred roughly from the nineteenth to the early twentieth century. See Shorter, *A History of Psychiatry*, 69-112.

⁶² *Ibid.*, 300.

⁶³ *Ibid.*; Of course, saying that psychodynamic-leaning psychiatrists were uninterested in diagnostics and classification must be considered a slight generalization, since Horowitz, Shatan, and other psychoanalysts who fought to ensure the creation of a “stress syndrome” were very interested in developing, at least in the case of PTSD, a model and framework that could be, and was used as the template for PTSD diagnostic criteria. Nevertheless, it is evident that during the time of psychoanalytic/psychodynamic prominence, diagnostics were not at the top of their priority list.

⁶⁴ John Feighner et al., “Diagnostic Criteria for Use in Psychiatric Research,” *Archives of General Psychiatry* 26, no. 1 (1972): 57-63; See also Kenneth Kendler, Rodrigo Munoz, and George Murphy, “The Development of the Feighner Criteria: A Historical Perspective,” *American Journal of Psychiatry* 167, no. 2 (2010): 134-142.

1970s.⁶⁵ Spitzer and a few colleagues refined Feighner's work, and came up with the "Research Diagnostic Criteria (RDC)," which for the first time attempted to use standard, fixed criteria for diagnosing mental disorders, instead of clinical experience and intuition, as had been the case for several decades.⁶⁶ Spitzer and his co-authors confidently wrote that, "The data presented ... indicate high reliability for diagnostic judgements made using these criteria."⁶⁷

Whereas previously a psychiatrist was required to spend a significant amount of time with a patient to arrive at a diagnosis, using fixed criteria (i.e., a patient must have symptoms "A" and "B" to have disorder "C"), that determination could be made in hours or minutes.⁶⁸ Moreover, once diagnoses were standardized, research could be focused and targeted, and clinicians could communicate across universities and countries, a previously difficult task when almost all disorders were thought to stem from a patient's idiosyncrasies and life-history.⁶⁹ The RDC and its adherents' position went against "decades of neglect" with regard to diagnosis and classification (sometimes termed "nosology").⁷⁰ Writing shortly after DSM-III's release in 1980, psychiatrist Gerald Klerman, a specialist in depression and schizophrenia, argued that the DSM-III approach was a clean break from psychodynamic attitudes toward diagnosis.⁷¹ He succinctly summarized the reason why most psychoanalysts ignored diagnosis and classification: "If all conditions [disorders] were indications for psychotherapy, then diagnosis and differential treatment were not necessary."⁷² Stated another way, if psychoanalysis was always the

⁶⁵ Wilson, "DSM-III and the Transformation of American Psychiatry," 404.

⁶⁶ Shorter, *A History of Psychiatry*, 300-301.

⁶⁷ Robert Spitzer, Jean Endicott, and Eli Robins, "Research Diagnostic Criteria: Rationale and Reliability," *Archives of General Psychiatry* 35, no. 6 (1978): 773.

⁶⁸ What Spitzer called "shared symptomatology."

⁶⁹ Shorter, *A History of Psychiatry*, 301.

⁷⁰ Gerald Klerman, "The Significance of DSM-III in American Psychiatry," in Robert Spitzer, Janet Williams, and Andrew Skodol, eds., *International Perspectives on DSM-III* (Washington, D.C.: American Psychiatric Press, 1983), 3.

⁷¹ Ibid.

⁷² Ibid.

prescribed treatment, the diagnosis was of secondary importance or none at all. Luckily for Spitzer and like-minded colleagues, he was appointed head of the task force to revise DSM-II, and was keen to use the RDC during DSM-III's editorial process.⁷³

Spitzer, who subsequently wrote extensively on his role in DSM-III's creation, aimed to make the new edition a distinct refocusing of American psychiatry toward what has been called "descriptive psychiatry," and more importantly, to have psychiatric diagnoses rooted in empirical data rather than individual case histories and clinical experience.⁷⁴ In contrast to DSM-II's editorial board, which consisted of many psychoanalytically-oriented members, the DSM-III task force was heavily "weighted against it [psychoanalysis]" and favoured the biological approach.⁷⁵ Spitzer, a deft politician, was careful to choose committee members whose research interests aligned with his own.⁷⁶ The goal was to produce, for the first time a "science-driven document." Thus, as much as possible, Spitzer's task force used research evidence to verify and refine diagnoses placed in DSM-III.⁷⁷ In a signal even prior to its publication that DSM-III was a revolutionary document, the U.S. National Institute of Mental Health (NIMH) sponsored a DSM-III trial run between 1977 and 1979 during which time 500 psychiatrists from many different centres used the new edition drafts to diagnose over 12,000 patients. After the diagnoses, psychiatrists were paired and their assessments were compared for consistency.⁷⁸ Such a large-scale diagnostic test had never been undertaken before. As a further testament to its

⁷³ The story of DSM-III's creation, told in numerous accounts, reads like the story of a coup d'état, with, in Shorter's words, a group of "Young Turks," APA Medical Director Melvin Sabshin among them, ensuring that Spitzer was appointed head of the DSM-III task force, since he was known by then as someone determined to make significant changes in psychiatric orientation. See Shorter, *A History of Psychiatry*, 301.

⁷⁴ Mitchell Wilson, "DSM-III and the Transformation of American Psychiatry," 400; Spitzer and Janet Williams, "International Perspectives: Summary and Conclusion," in Spitzer, Williams, and Skodol, *International Perspectives*, 352.

⁷⁵ Shorter, *A History of Psychiatry*, 301.

⁷⁶ Healy, *The Creation of Psychopharmacology*, 302.

⁷⁷ Shorter, *A History of Psychiatry*, 302.

⁷⁸ Ibid.

revolutionary nature, upon its release in 1980 DSM-III was almost 500 pages long, with many pages containing long lists of diagnostic criteria. The new Manual's bulk was a far cry from the first and second editions, which were 130 and 134 pages respectively.⁷⁹

With DSM-III, Spitzer and his colleagues were also aware of, and responding to, serious pressures on their profession in the 1960s and 1970s. The first challenge related to pharmaceutical drugs and drug research. With the widespread use of drug therapies for psychiatric patients by the 1960s, diagnosis became a practical and sometimes crucial matter for both treatment and targeted research.⁸⁰ In addition, major sources of research money and funding for treatment, namely the NIMH and insurance companies, began to demand more reliable diagnoses, greater accountability, and evidence-based practice.⁸¹ Under those conditions, numerous psychiatrists retreated from the psychoanalytical approach and toward the biological one. Consequently, "psychoanalysis lost its identification with psychiatric reform."⁸²

A second pressure came from a number of studies within and outside the profession which displayed the woeful state of psychiatric diagnoses and a lack of diagnostic uniformity. One example was a 1970 cross-national NIMH-funded British and American study on the diagnosis of patients in London and New York City psychiatric hospitals. Focusing exclusively on schizophrenia, the researchers studied 192 patients from New York and 174 from London. They concluded there was an evident lack of consensus – in fact, major discrepancies – in how schizophrenia was appraised and diagnosed in each country. The discrepancies, according to the study's researchers, were, "primarily a result of differences in the way the two groups of hospital psychiatrists diagnose patients" and not the result of any differing psychopathology exhibited by

⁷⁹ Ibid.

⁸⁰ Ibid., 297.

⁸¹ Wilson, "DSM-III and the Transformation of American Psychiatry," 403.

⁸² Hale, *The Rise and Crisis of Psychoanalysis*, 300.

patients.⁸³ Essentially, psychiatric diagnostics failed to achieve a uniform or “scientific” standard.⁸⁴ That two groups, albeit from different countries, could not reach a consensus on a major mental illness like schizophrenia, left the impression that psychiatrists were using idiosyncratic rather than empirical considerations when making their determinations.

The second and more troubling study was published in 1973 in the prominent journal *Science* under the title “On Being Sane in Insane Places.” Psychologist David Rosenhan, professor at Stanford University, sent a group of healthy individuals to twelve psychiatric hospitals across the United States, each feigning symptoms of schizophrenia. Claiming to need treatment, the “pseudo-patients” were voluntarily admitted and subsequently reported their experiences within the institution. They also described their unsuccessful attempts to achieve release upon claiming they had recovered from their illness.⁸⁵ In all cases except one, the pseudo-patients were admitted, and once admitted, were forced to adopt a drug therapy regimen as a condition of their release. Rosenhan’s test drew attention to the power of “labels,” that is the power of diagnoses to “stick” and stigmatize, influencing patient and practitioner once given. The test also drew attention to the dehumanizing nature of large hospitals. But Rosenhan’s most powerful intellectual indictment related to the continued use of psychiatric diagnoses despite their evident unreliability: “The facts of the matter are that we have known for a long time that diagnoses are often not useful or reliable, but we have nevertheless continued to use them.”⁸⁶ He delivered an even more scathing volley, affirming that, “We now know that we cannot distinguish insanity from sanity.”⁸⁷ On top of the embarrassment for psychiatrists, such studies also fuelled the “antipsychiatry” movement, a misnomer applied to a diverse group of thinkers

⁸³ Psychopathology here means “deviations from normal behaviour or manifest symptoms.”

⁸⁴ Barry Gurland et al., “Cross-National Study of Diagnosis of Mental Disorders: Hospital Diagnoses and Hospital Patients in New York and London,” *Comprehensive Psychiatry* 11, no. 1 (1970): 24.

⁸⁵ D.L. Rosenhan, “On Being Sane in Insane Places,” *Science* 19, no. 4070 (1973): 250-258.

⁸⁶ *Ibid.*, 256.

⁸⁷ *Ibid.*

that in the 1960s and 1970s published critiques whose common ground was that, “psychiatric illness is not medical in nature but social, political, and legal.”⁸⁸

Spitzer, who directly responded to Rosenhan’s study with his own 1976 article, was acutely aware of the popularity of critiques against diagnostic labels, but nonetheless affirmed that “when properly used, they have been shown to be of considerable value.”⁸⁹ Spitzer’s aims with DSM-III were, among other things, to defeat critics like Rosenhan and place psychiatry on a more scientific footing. Thus, when DSM-III was finally released in 1980, the anticipation, controversy, and immediate impact were evident in the number sold. Within six months of its publication, more people ordered DSM-III than all previous editions combined, including their thirty-plus reprints.⁹⁰ Whether critics or supporters, all noted that DSM-III signaled a new era in psychiatry; historians agreed. Edward Shorter called it: “[A]n event of capital importance, not just for American but for world psychiatry, a turning of the page on psychodynamics, a redirection of the discipline toward a scientific course, a reembrace of the positivistic principles of the nineteenth century, [and] a denial of the antipsychiatric doctrine of the myth of mental illness.”⁹¹ Psychoanalyst Mitchell Wilson called the DSM-III story “a story about the changing power base, as well as the changing knowledge base, within American psychiatry,” noting how

⁸⁸ Shorter, *A History of Psychiatry*, 274; As Shorter noted, much of this movement stemmed from the spirit of the 1960s and its emphasis on hostility to authority, which the medical profession, and especially psychiatry with its emphasis on controlling deviant behaviour and thoughts, seemed to represent. There are any number of works that could be cited here, but several of the most prominent are: Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: HarperCollins, 1961); Thomas Scheff, *Being Mentally Ill: A Sociological Theory* (New York: Aldine de Gruyter, 1999 [1966]); R.D. Laing, *The Politics of Experience* (New York: Ballantine Books, 1967); Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. Richard Howard (New York: Pantheon Books, 1967 [1961]); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, New York: Anchor Books, 1961).

⁸⁹ Robert Spitzer, “More on Pseudoscience in Science and the Case of Psychiatric Diagnosis,” *Archives of General Psychiatry* 33, no. 4 (1976): 469.

⁹⁰ Rick Mayes and Allan Horwitz, “DSM-III and the Revolution in the Classification of Mental Illness,” *Journal of the History of the Behavioral Sciences* 41, no. 3 (2005): 263-264.

⁹¹ Shorter, *A History of Psychiatry*, 302.

clinicians were replaced by biomedical researchers as the most influential voices in the field.⁹² Psychopharmacologist and historian David Healy argued that DSM-III's popularity indicated "the importance that psychiatry had assumed in the popular mind."⁹³ Although both DSM-III critics, political scientist Rick Mayes and sociologist Allan Horwitz nonetheless pointed to its powerful impact, stating that "for the first time, psychiatrists, psychologists, social workers, and counselors had one common language to define mental disorders."⁹⁴

Politics, Trauma, and Popular Perceptions

By providing a common language and symptom profile to conceptualize PTSD, DSM-III contributed to the monumental growth of research into psychological trauma in the 1980s and beyond. In medical circles and the popular mind PTSD created a common framework for how all humans responded to trauma, helping to build bridges between war trauma and the myriad ways civilians were also affected by harrowing events.⁹⁵ Psychiatrist and researcher into the socio-cultural underpinnings of PTSD Derek Summerfield stated that PTSD was "the flagship of this medicalized trauma discourse," a discourse which spread rapidly in the United States after 1980.⁹⁶ But the PTSD concept's osmosis into popular consciousness was uneven throughout the next few decades, and although immediately felt in the United States, PTSD's entry was somewhat muted in Canada, a nation that in 1980 had not been at war for almost thirty years.

Although the PTSD concept provided American Vietnam veterans with symbolic and literal compensation for their psychological injuries and social alienation, the estimated 12,000 Canadians who fought with U.S. forces in Vietnam had their postwar troubles go unnoticed by

⁹² Wilson, "DSM-III and the Transformation of American Psychiatry," 408.

⁹³ Healy, *The Creation of Psychopharmacology*, 305.

⁹⁴ Mayes and Horwitz, "DSM-III and the Revolution," 263.

⁹⁵ Shephard, *A War of Nerves*, 385.

⁹⁶ Derek Summerfield, "A Critique of Seven Assumptions Behind Psychological Trauma Programmes in War-Affected Areas," *Social Science and Medicine* 48, no. 10 (1999): 1450.

the Canadian public throughout the 1980s.⁹⁷ There were a few key reasons for their invisibility: Since Canada was officially a non-belligerent during the conflict, many Canadians viewed those who volunteered to fight with the United States as morally questionable mercenaries.⁹⁸ Others, sensitive to Canada's role as a haven for thousands of American draft dodgers, horrified at the images brought to their living room through the relatively new medium of television, and attuned to antiwar sentiments prevalent across North America, viewed Vietnam veterans as "baby killers."⁹⁹ Doug Clark, a freelance writer researching a book on Canadian Vietnam veterans in 1984, stated in a *Globe and Mail* article that there were "few charitable adjectives" used towards those who fought with the Americans.¹⁰⁰ In addition, the Royal Canadian Legion denied Canadian Vietnam veterans full membership and denied them participation in Remembrance Day ceremonies.¹⁰¹ Lastly, due to the murky number of Canadians in the war and their unpopular decision to participate, newspaper coverage was strikingly sparse. The net effect was that most men opted to stay out of the public eye, preferring to keep their war service, and subsequent troubles, a secret known only to their closest family and friends.¹⁰² Canadian Vietnam veterans became in effect "Canada's unknown warriors."¹⁰³

Despite their relatively hidden existence within Canadian society throughout the 1970s and beyond, there were ephemeral signs numerous Canadian Vietnam veterans were suffering like their American counterparts.¹⁰⁴ Doug Clark's article argued that in a few key respects

⁹⁷ Tracey Arial, *I Volunteered: Canadian Vietnam Vets Remember* (Winnipeg: Watson & Dwyer, 1996), 9; As Fred Gaffen highlighted, despite Canada not being officially involved, Canadian businesses participated obliquely in the Vietnam War through billions of dollars of war materiel supplied to American firms. See Fred Gaffen, *Unknown Warriors: Canadians in Vietnam* (Toronto: Dundurn Press, 1990), 9 and 36; Participant figures are taken from Gaffen, 36.

⁹⁸ Gaffen, *Unknown Warriors*, 9.

⁹⁹ Ibid.

¹⁰⁰ *The Globe and Mail*, 9 July 1984.

¹⁰¹ Gaffen, *Unknown Warriors*, 14.

¹⁰² Ibid., 13.

¹⁰³ Ibid.

¹⁰⁴ Those signs went largely unnoticed by all except specialists and a few interested researchers.

Canadian veterans had a *more* difficult postwar adjustment, namely due to the “absence of a readily identifiable peer group and lack of competent medical help.”¹⁰⁵ According to Clark, the roughly 20% of Canadian veterans afflicted with various mental disorders, the most common of which was PTSD, were “further disadvantaged by a [Canadian] medical profession that either cannot or will not address itself to medical concerns judged legitimate by U.S. colleagues.”¹⁰⁶ His article scathingly attacked not just the medical profession, but also the Canadian public, who had in the “finest Canadian tradition” denounced the Vietnam war and its veterans without acknowledging the profits accumulated by Canadian corporations that manufactured all varieties of war matériel for the United States, including green berets and defoliants.¹⁰⁷

Two years later the *Toronto Star* published an article about Canadian Vietnam veterans and the “void” they returned to after the war. Pointing to the differences between Canadian and American veterans, the author wrote that Canadians “were ignored” and “remained isolated, not even knowing each other.”¹⁰⁸ One veteran reported having flashbacks of a terrified comrade’s face even ten years after the war’s end, something that caused him to “stay away from people.” Others expressed strong feelings of alienation, particularly since the Canadian government did not provide aid while the U.S. Department of Defense refused to admit any Canadians participated in the war.¹⁰⁹ Alex Mills, nineteen-years-old when he volunteered to fight in Vietnam, lamented: “The experiences were brutal enough in the combat zones, but they seemed worse once we got home.”¹¹⁰ The article’s author demonstrated the relative lack of knowledge about PTSD among the public in the 1980s when he identified the stress-related disorder

¹⁰⁵ *Globe and Mail*, 9 July 1984; Clark’s figure was taken from an estimate that 80% of U.S. veterans returned home and adjusted without major difficulties.

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ *The Toronto Star*, 6 July 1986.

¹⁰⁹ *Ibid.*

¹¹⁰ *Ibid.*

numerous Canadian veterans displayed not as PTSD, but its former name: “post-Viet Nam syndrome.”¹¹¹

South of the border, in 1985 *The New York Times* also spotlighted Canadian Vietnam veterans’ plight in a two-page article.¹¹² Utilizing several interviews, the article highlighted the socio-economic difficulties facing veterans, including limited access to benefits from the American government, none from the Canadian government, and being shunned by the Canadian public.¹¹³ Veterans’ anecdotal evidence pointed to the psychological troubles those men shouldered, including one veteran described as a “pill-popping former paratrooper who insisted on walking around Montreal armed.”¹¹⁴ Interviewees also drew attention to the dearth of knowledge among Canadian physicians about “post-Vietnam stress disorders that American doctors have begun to recognize.”¹¹⁵ One veteran laconically summed up the situation, saying that, “They [Canadian doctors] want to commit you or incarcerate you.” Another spoke of contemplating suicide before finally checking himself into a hospital for assessment.¹¹⁶ Tallying up the situation amongst his comrades, a Marine veteran appropriately named Teddy Canadian declared that, “Some of these guys are still [psychologically] in Vietnam... They are in bad shape but they won’t admit it.”¹¹⁷ Vern Murphy, spokesman for the DVA, bluntly declared that Canadian Vietnam veterans could not “be a burden on the Canadian taxpayer, because we weren’t involved in it [the war].”¹¹⁸ His comment displayed the distance both the public and

¹¹¹ Ibid.

¹¹² *New York Times*, 24 January 1985.

¹¹³ Ibid; Canadians were entitled to most benefits through the United States Veterans Administration except for a few, such as housing loans. The problem for most was that free medical care for war-related problems had to be sought at a Veterans Administration hospital or other approved American facility. This meant in practice that some men had to travel extremely long distances into the United States for care.

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Ibid.

¹¹⁷ Ibid.

¹¹⁸ Ibid.

federal government placed between themselves and Vietnam.¹¹⁹ Unfortunately, fragmented but poignant testimony also showed the distance Vietnam veterans placed between themselves and Canadian society.

Veterans' anecdotes also raised the issue of the degree to which Canadian physicians ignored or dismissed veterans with PTSD symptoms. The answer, pieced together by examining Canadian medical publications in the 1980s and supporting works on PTSD outside of the United States, was that Canadian mental health professionals, save for a few researchers, were largely uninterested in PTSD and/or unaware of its existence. Colloquially put, PTSD was not a "hot" topic in Canada like it was in the United States during the 1980s. Joel Paris, prolific writer on psychiatric topics and current editor of the *Canadian Journal of Psychiatry* stated in correspondence: "Everybody [psychiatrists] accepted PTSD as a diagnosis after 1980, but I can't think of anyone who studied it in those early years."¹²⁰ There were in fact no articles about PTSD in the *Canadian Medical Association Journal* during the 1980s. A 1985 editorial about Canadian physicians in the Second World War made passing references to battle exhaustion, but drew no links to postwar psychiatric problems and did not connect the term with later knowledge about PTSD.¹²¹ Likewise a 1987 article about Canadian prisoners of war from the Battle of Hong Kong (1941) cited almost 200 veterans who developed "psychiatric problems as a result of their imprisonment," but the author made no mention of PTSD and never used the DSM-III concept of trauma.¹²²

The *Canadian Journal of Psychiatry*, the CPA's official journal, made only two specific mentions of PTSD throughout the entire decade, including in articles, editorials, and subscriber

¹¹⁹ Ibid.

¹²⁰ Joel Paris, e-mail message to author, April 14, 2015.

¹²¹ David Woods, "Canadian Physicians in World War II," *Canadian Medical Association Journal* 132, no. 10 (1985): 1103.

¹²² Patrick Sullivan, "War Ended Decades Ago, but PoWs' Problems Continue," *Canadian Medical Association Journal* 137, no. 9 (1987): 837.

letters.¹²³ In the first instance, a 1985 short article focusing on PTSD after car accidents was conducted by a group of researchers at the University of Toronto.¹²⁴ In the second instance, a 1987 letter to the editor on “Management of Post Traumatic Stress Disorder and Ethnicity” cited the case of a Vietnamese immigrant who was committed to a provincial psychiatric hospital after threatening his apartment caretaker with a knife.¹²⁵ Believing that communists from Vietnam were in Canada and plotting to kill him, the man also experienced recurring nightmares and appeared to be reliving traumatic moments from his past life. The article’s author, somewhat aware of current trauma literature, noted that “The catastrophic effect of the Vietnam War may have influenced the emergence of the Post Traumatic Stress Disorder as a distinct syndrome.”¹²⁶

One lone researcher, Robert Stretch, a psychologist and U.S. Army Major, studied the Vietnam War’s effects on Canadian personnel.¹²⁷ Stretch published three articles, two in 1990 and one in 1991, which examined the psychological and social adjustment of Canadian veterans who had served in combat and peacekeeping roles.¹²⁸ With regard to the former group, he concluded that not only did Canadian Vietnam veterans have “significantly greater rates of posttraumatic stress disorder” compared with U.S. combat veterans, but that part of their illness stemmed from “prolonged isolation from other Vietnam veterans, lack of recognition, and no

¹²³ This number marginally rises to three when including a 1980 case report that utilized the concept of traumatic neurosis. The author, George MacLean, a child psychiatrist and assistant professor of psychiatry at McGill, displayed his psychodynamic (Freudian) leanings when he described the case of a three-year-old boy attacked by a leopard. He stated that the boy’s “well-endowed ego was overwhelmed” due to “coexisting feelings of fear, anger and guilt resulting from the age appropriate oedipal strivings.” See George MacLean, “Addendum to a Case of Traumatic Neurosis,” *Canadian Journal of Psychiatry* 25, no. 6 (1980): 506.

¹²⁴ Klaus Kuch, “Post-Traumatic Stress Disorder after Car Accidents,” *Canadian Journal of Psychiatry* 30, no. 8 (1985): 426-427.

¹²⁵ R. Varadaraj, “Management of Post Traumatic Stress Disorder and Ethnicity,” *Canadian Journal of Psychiatry* 33, no. 1 (1987): 75.

¹²⁶ Ibid.

¹²⁷ To the best of my knowledge Stretch’s studies are still the only of their kind as of 2015.

¹²⁸ Robert Stretch, “Effects of Service in Vietnam on Canadian Forces Military Personnel,” *Armed Forces and Society* 16, no. 4 (1990): 571-585; Stretch, “Post-Traumatic Stress Disorder and the Canadian Vietnam Veteran,” *Journal of Traumatic Stress* 3, no. 2 (1990): 239-254; Stretch, “Psychosocial Readjustment of Canadian Vietnam Veterans,” *Journal of Consulting and Clinical Psychology* 59, no. 1 (1991): 188-189; The first article focused on Canadian military personnel serving in a peacekeeping role while the second focused on combat soldiers.

readily available treatment for PTSD in Canada.”¹²⁹ Presciently, Stretch’s 1990 study of 121 Canadians who served in a peacekeeping role in Vietnam suggested that “one does not have to be a combatant to be traumatized by war,” and that social support (or lack of) after returning home had a marked effect on the prevalence of PTSD in the group studied.¹³⁰ All three of Stretch’s articles pointed to the importance of social support for peacekeeping and combat missions. There was, however elusive, a crucial link between a participant’s ability to connect his acts and experiences to a tangible, supported cause, and his mental health after service.¹³¹

The scarcity of research about PTSD and Canadian Vietnam veterans’ health problems were also related to another factor. Given the emergence of PTSD as a result of the Vietnam War and its political aftermath, many experts initially felt PTSD to be a disorder unique to that conflict and its veterans, rather than a universal phenomenon. Much like how shell shock and battle exhaustion became manifestations associated with the First and Second World Wars, PTSD became linked to the uniquely stressful experiences of Vietnam, a war often conducted in the jungle, where the enemy was an ephemeral, ghostly figure, rarely heard and even more rarely seen.¹³² Building on this view, others attributed the Vietnam War’s aftershocks to its polarizing nature and the divided American social climate, particularly since most veterans developed psychological difficulties at home as opposed to in theatre.¹³³ Taken together, it was easy for researchers in Canada and elsewhere to dismiss PTSD as a primarily U.S., Vietnam-specific phenomenon.

As a useful comparison, in the United Kingdom, like in Canada, PTSD had an initially slow entry into research circles and the public forum. A 1981 historical survey of trauma by

¹²⁹ Stretch, “Psychosocial Readjustment of Canadian Vietnam Veterans,” 188-189.

¹³⁰ Stretch, “Effects of Service in Vietnam,” 583.

¹³¹ Ibid., 584.

¹³² Binneveld, *From Shell Shock to Combat Stress*, 83.

¹³³ Jones and Wessely, *Shell Shock to PTSD*, 131.

Michael Trimble, researcher and lecturer in neuropsychiatry at the National Hospital for Nervous Diseases in London, utilized the historical concept of “post-traumatic neurosis” rather than “post traumatic stress disorder” in its title, and never specifically mentioned the latter concept throughout.¹³⁴ Trimble later revealed that when writing his book DSM-III had not yet been published and by its publication in 1981 PTSD, “concocted largely by political veterans was not within the general psychiatric community.”¹³⁵ Trimble, as with numerous psychiatrists outside of the United States, believed PTSD to be a re-branding of “patterns” observed for hundreds of years, rather than a new and scientifically-based disorder.¹³⁶ Thus, the PTSD concept was not granted immediate acceptance in Britain as it was in the United States.¹³⁷ Anecdotal evidence, as well as PTSD’s absence from British psychiatric textbooks in the early- to mid-1980s also pointed to the disorder’s slow and muted entry into British civilian psychiatric circles.¹³⁸ As in the United States, PTSD only became a front-page news item in the United Kingdom after the beginning of another war.

Between the end of the Korean War and the 1980s, Britain was involved in only one major military campaign – the Suez Crisis of 1956. Consequently, when the Falklands War began in April 1982, British Royal Navy psychiatrists were aware of PTSD but deemed it a disorder specific to American Vietnam War conscripts.¹³⁹ The Falklands War’s short duration, as well as – in contrast to the Vietnam veteran’s experience – the great honours and recognition its participants received upon their return to the United Kingdom, helped create the impression that,

¹³⁴ Copp and Humphries, *Combat Stress*, 419; Michael Trimble, *Post-Traumatic Neurosis: From Railway Spine to the Whiplash* (Toronto: John Wiley & Sons, 1981), 153.

¹³⁵ Michael Trimble, e-mail message to author, April 22, 2015

¹³⁶ Ibid.

¹³⁷ Trimble, *Post-Traumatic Neurosis*, 3; Edgar Jones and Simon Wessely, “A Paradigm Shift in the Conceptualization of Psychological Trauma in the 20th Century,” *Journal of Anxiety Disorders* 21, no. 2 (2007): 173.

¹³⁸ Copp and Humphries, *Combat Stress*, 419.

¹³⁹ Shephard, *A War of Nerves*, 378.

as in the early stages of Vietnam, war-related mental disorders were a rare and insignificant problem.¹⁴⁰ Psychiatric casualties during the Falklands War were reported as being only 2% of the total number of wounded; a far smaller figure than during past conflicts.¹⁴¹ Nevertheless, in a similar pattern to the Vietnam War, several years after their return numerous British veterans reported service-related psychological problems.¹⁴² While there was no consensus on the precise number of veterans with PTSD, comprehensive press coverage and widespread public interest in both the war and its consequences brought war-related mental disorder to the forefront in a manner unseen since the Second World War.¹⁴³

As government officials did in past conflicts, the British Ministry of Defence (MOD) initially denied PTSD or other psychiatric consequences were related to the war, and military physicians followed suit.¹⁴⁴ But by 1986, with growing public pressure stemming from a number of news stories about suffering veterans, the MOD was forced to recognize PTSD as a disorder not limited to America. Nonetheless, in a testament to the strength of military culture and the traditional warrior ethos, British military physicians and officers were still divided on the issue, with some stubbornly viewing war-related trauma as indication of a weak character, and one Army college lecturer using the term “Compensation-itis” to describe PTSD.¹⁴⁵ Despite the relatively low number of Falklands War casualties, it became difficult for the Ministry to maintain its position in the face of evidence that many men were witness to horrific scenes, such as one naval veteran injured by a bomb blast who returned below deck to find his best friend’s mutilated body.¹⁴⁶ The MOD nevertheless maintained a hard stance on the issue, refusing to

¹⁴⁰ Ibid., 378.

¹⁴¹ Jones and Wessely, *Shell Shock to PTSD*, 136.

¹⁴² Shephard, *A War of Nerves*, 378.

¹⁴³ Ibid., 378-379; Jones and Wessely, *Shell Shock to PTSD*, 166.

¹⁴⁴ Shephard, *A War of Nerves*, 378.

¹⁴⁵ Ibid., 379.

¹⁴⁶ Ibid.

carry out a large survey of Falklands veterans for fear of leaving the government open to litigation from ex-servicemen claiming the Ministry failed in its “duty of care.”¹⁴⁷

By the 1990s numerous veterans went ahead regardless and sued the MOD for medical negligence, on the grounds that inadequate care was given to detect and treat PTSD during and after the Falklands War.¹⁴⁸ Their litigation culminated in a 2003 High Court decision which rejected the claims of more than 2000 military veterans from various wars that the MOD had failed in its duty of care.¹⁴⁹ The Court’s decision, among other things, seemed to fly in the face of a 2002 article from *The Mail on Sunday* which claimed more Falklands veterans had committed suicide since 1982 than had died in combat.¹⁵⁰ One of the main factors on which the Court’s decision hinged was that during the early 1980s British military authorities and psychiatrists believed that PTSD was a Vietnam-specific disorder. The judge ruled “it was reasonable for the MOD to assume that this [PTSD] was due to factors specific to that war [Vietnam], or indeed not so much the war itself, but America’s reaction to it.”¹⁵¹ The landmark trial highlighted that while the MOD was not obligated to provide a duty of care above and beyond that of any other employer, military authorities were now unable to deny the existence of war-related mental disorders or easily dismiss them as weakness of character.¹⁵² The Falklands War had, like Vietnam in America, brought war-related trauma into public consciousness in the United Kingdom. Although the Falklands War differed from Vietnam in some key respects, such as the great public adulations and societal support given to Falklands’ veterans, much of the

¹⁴⁷ Ibid., 381.

¹⁴⁸ Ibid.

¹⁴⁹ T. McGeorge, J. Hacker Hughes, and Simon Wessely, “The MOD PTSD Decision: A Psychiatric Perspective,” in Copp and Humphries, *Combat Stress*, 489.

¹⁵⁰ *The Mail on Sunday* (London), 13 January 2002; The South Atlantic Medal Association, which represented and aided Falklands veterans, believed that 264 veterans had committed suicide, as opposed to 255 who died during the war.

¹⁵¹ McGeorge, Hughes, and Wessely, “The MOD PTSD Decision,” 493.

¹⁵² Ibid., 492.

historical pattern was similar. After the Falklands, PTSD became a widely accepted consequence of war.¹⁵³ Moreover, the Falklands War, like future peacekeeping operations in Canada during the 1990s, helped create the impression that PTSD was not an American, Vietnam-specific disorder, but a universal reaction to trauma.

¹⁵³ This support was, if not financial, at least social.

CHAPTER 4: PEACEKEEPING, POLITICS, AND PERCEPTIONS

It isn't Sesame Street out there.¹

That [peacekeeping] is a bullshit word. In Cyprus, that was peacekeeping. You've got a buffer zone, a demilitarized zone keeping warring factions at bay. Bosnia-Herzegovina wasn't peacekeeping – or Croatia or Kosovo or Somalia or Rwanda. None of those were peacekeeping missions. They're war monitoring and you're in it, baby, you're right in the middle of it.²

During his twenty years in the Canadian Armed Forces, from 1986 until retirement in 2006, retired Warrant Officer Andrew Godin bore witness to historic changes in the nature of peacekeeping operations throughout the world.³ As with numerous CAF members during the 1980s, Godin's first overseas tour as part of the long-established (since 1964) United Nations Peacekeeping Force in Cyprus, was one of relative calm.⁴ Although there were occasional incidents, UN peacekeepers occupied a well-established buffer zone between the opposing Greek and Turkish sides, and were generally able to carry on their duties without fear of injury or death.⁵ Many Canadian peacekeepers, Godin included, jokingly referred to the mission as a "Club Med" vacation, given the island's generally relaxed atmosphere and balmy climate.⁶

¹ James Davis, *The Sharp End: A Canadian Soldier's Story* (Toronto: Douglas & McIntyre, 1997), 205.

² John Wood, "Tom Martineau: Warrant Officer," in, John Wood, ed., *The Chance of War: Canadian Soldiers in the Balkans 1992-1995* (Toronto: Breakout Education Network in Association with Dundurn Press, 2003), 183.

³ Godin, Andrew. Interview by author. Telephone. Toronto, July 20, 2014.

⁴ UN forces were first deployed to Cyprus in 1964 to quell and prevent inter-communal violence between Turkish and Greek Cypriots on the island. As part of United Nations Security Council Resolution 186, UN peacekeeping forces were established to create and maintain a buffer zone between the two sides. As of 2015 the mission is still ongoing, and is one of the longest running UN peacekeeping efforts, despite being largely unknown. See United Nations, "Resolutions Adopted by the United Nations Security Council in 1964." <http://www.un.org/en/sc/documents/resolutions/1964.shtml> (accessed May 11, 2015).

⁵ This does not mean, of course, that the mission was one of complete relaxation. Godin recalled a few "unnerving incidents," which included having to quell a large Greek Cypriot women's demonstration with no weapon while being subjected to spitting, shoving, and yelling. In one particular instance, over 3000 women were involved in a march into Turkish held territory that led to numerous injuries and arrests. See *The New York Times*, 20 March 1989, for coverage of an incident Godin was personally involved in quelling. Fred Doucette likewise highlighted some of the harrowing moments he encountered in Cyprus during the 1970s, including the bombing of the Nicosia law courts. See Fred Doucette, *Empty Casing: A Soldier's Memoir of Sarajevo Under Siege* (Toronto: Douglas & McIntyre, 2008), 17.

⁶ Andrew Godin, e-mail message to author, May 5, 2015; Godin's appraisal is backed up by numerous other accounts from Canadians who participated in the Cyprus mission. See, for example, Warrant Officer Matt Stopford's comments about Cyprus: "I'm tempted to say that Cyprus was like a holiday. Now and then somebody

Unfortunately, Cyprus was a benchmark that proved ill-suited to preparing peacekeepers for future operations. Testifying before the Croatia Board of Inquiry in September 1999, Chief Warrant Officer (ret.) M.B. McCarthy stated:

I have done four tours there, Cyprus killed us. Cyprus was the worst thing that has ever happened to us. Cyprus put NCOs [Non-Commissioned Officers], not so much soldiers, but NCOs in a mindset. Even though we were there for 20-some odd years and everyone knew it was a party and it was. Cyprus was a good time, a good tour. Seventy-four ('74) wasn't a good time, you know, but after that it was great. And some people, some NCOs went over, 'We are going to Yugoslavia. Another UN mission. More partying.' Things changed dramatically.⁷

Thus when Godin and his regiment, 4 Combat Engineer Regiment, arrived in the former Yugoslavia in 1992 as part of the United Nations Protection Force (UNPROFOR), the sights, sounds, and events he witnessed affected him long after his tour ended. He learned early on that in conflicts fueled by ancient, ethnic hatreds, traditional ideas of respect for one's foe, and even the sanctity of human remains, meant little to its participants. In Croatia he saw a dead Serbian soldier "dragged through the streets like a dog" and thrown into a river "like a piece of garbage."⁸ He recalled seeing numerous "floating, bloating bodies" that moved downriver and at first glance reminded him of swans.⁹ On another occasion his unit came upon a local spa where the entire outdoor pool was filled with the bodies of Serbians who had not heeded Croatian threats to leave. And in several instances Godin saw Croat and Serb combatants' skeletal remains on the side of the road, left to rot because they were in a sniper zone and no one from either side

got shot or there was a riot, but it wasn't a big deal and you did your job. It was like a picnic." Fred Doucette wrote that in Cyprus he "saw drunkenness on a level" that would shock both civilians and soldiers. See John Wood, "Matt Stopford: Warrant Officer" in *The Chance of War*, 124; Doucette, *Empty Casing*, 16.

⁷ Testimony of CWO M.B. McCarthy, *Croatia Board of Inquiry – Potential Exposure of Canadian Forces Personnel to Contaminated Environment*, November 25, 1999, vol. IX, 28; Hereafter referred to as *Croatia Board of Inquiry*.

⁸ Godin interview.

⁹ Ibid.

dared venture out and risk being shot attempting a recovery.¹⁰ Appraising his tour, Godin bluntly stated, “That’s what you witnessed, that’s what you saw.”¹¹ Making the situation even more difficult to process was the fact that Godin and his comrades were unable to intervene in tragedies they witnessed because it was not part of their UN mandate; a mandate which in Croatia often made them “incidental bystanders at someone else’s battle.”¹² After relating the above events in an interview, Godin paused for a few moments and then quietly said, “Those are the things that eat away at you.”¹³

Upon his return from Croatia and Bosnia in late 1992, Godin sensed something was wrong when he experienced difficulty falling asleep, followed by nights filled with “massive nightmares.”¹⁴ He also felt increasingly jumpy and noticed that sudden noises jarred and unnerved him.¹⁵ Unable to put a name to his troubles, he began drinking heavily in his off time to forget about his experiences, and carried on with his work. A few years later, Godin sat in a military classroom during a pre-screening prior to a Bosnia deployment while a “suit” – CAF slang for a civilian Department of National Defence worker – discussed PTSD symptoms. Checking off most of the symptoms in his head, Godin later made an appointment with a social worker from National Defence Headquarters (NDHQ) in Ottawa while on a six month training course. He remembered sitting down and presenting his overseas experiences and subsequent psychological difficulties for “quite a few hours.” He was nonetheless told afterward that things would get better with time, and to carry on.¹⁶ So he did just that, returning to the former

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid; Carol Off, *The Ghosts of Medak Pocket*, 2.

¹³ Godin interview.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.

Yugoslavia two more times, first to Bosnia in 1996, and again to Kosovo and Macedonia in 1999-2000.

Godin likened his worsening situation to a bank vault: “What do you do with that stuff? [trauma] You package it up and say to yourself, ‘I’ll deal with this later,’ and you tuck it away in this bank vault, never to see the light of day again ... Because if you stop to think about it you’re going to shut down ... And you won’t be able to do your job ... Well, one day, your bank vault is full.”¹⁷ He knew his vault was full when one night during the Christmas season he found himself contemplating how to drive his car off the Bank Street Bridge in Ottawa and make it look like an accident. The next day, he went to the National Defence Medical Centre and spoke with his doctor. After sitting down with a social worker, psychologist, and finally a psychiatrist, he was diagnosed with PTSD in 2003, roughly ten years after his initial concerns.

Godin’s journey from health to illness, and his peacekeeping experiences, mirrored larger developments within the Department of National Defence (DND) and Canadian society during the 1990s. While Godin struggled with an individual, personal understanding of his psychological difficulties, at a macro level the CAF, DND, and Canadian public struggled with their own understanding and recognition of peacekeeping operations’ traumatic effects on soldiers. By the late 1990s, with numerous cases of peacekeepers’ trauma coming to light in military circles and the press, Canadians were, for the first time, exposed to what journalist Carol Off retrospectively called “Canadian post-traumatic stress disorder that comes from peacekeeping.”¹⁸ The Canadian experience was unique because unlike in Britain and the United States, it was not war per se, but “military operations other than war” that brought attention to

¹⁷ Ibid.

¹⁸ *The Globe and Mail*, 4 December 2004.

psychological trauma.¹⁹ By the new millennium, peacekeepers' trauma had not only shattered many Canadian soldiers' minds, it also challenged traditional myths and attitudes about mental illness and masculinity, and demonstrated that in many instances there was little peace involved in peacekeeping.

Peacekeeping – The Suez Crisis, a Nobel Prize, and National Identity

Three years after the end of the Korean War in 1956, the Suez Crisis erupted after Israel, Britain, and France invaded Egypt, in the British case as a response to Egyptian President Gamal Abdel Nasser nationalizing the Suez Canal Company.²⁰ The tense months that followed after the United States, the Soviet Union, and Canada, among others, pressured the Israelis, French, and British to withdraw have been described as one of the death throes of the British Empire and some of the darkest hours after the Second World War.²¹ Suez was, put simply, when “the [British] lion roared for the last time.”²² For Canada though, Secretary of State for External Affairs Lester Pearson's prominent role in helping to defuse the situation and create a United Nations Emergency Force (UNEF) to quell further violence led to a new Canadian specialty - peacekeeping.²³ The “Pearsonian” model of peacekeeping, in which neutral UN troops deployed to a buffer zone with conflicting parties' consent to enforce an accepted ceasefire, was the

¹⁹ Allan English, “From Combat Stress to Operational Stress: The CF's Mental Health Lessons From the ‘Decade of Darkness,’” *Canadian Military Journal* 12, no. 4 (2012): 11.

²⁰ The British invaded largely because the Suez Canal was at that time considered the “swing-door of the British Empire,” due to its crucial role in allowing the shipment of oil and also as a strategic thoroughway for British ships in the case of war. See Keith Kyle, *Suez: Britain's End of Empire in the Middle East* (London: I.B. Tauris, 2003 [1991]), 7-21.

²¹ Kyle summed up the situation by stating that after Suez Britain became convinced that there would be “no more solo flights” in foreign policy. See Kyle, *Suez*, 583.

²² Chester Cooper, *The Lion's Last Roar: Suez, 1956* (New York: Harper & Row, 1978), 282.

²³ Jocelyn Coulon, *Soldiers of Diplomacy: The United Nations, Peacekeeping, and the New World Order*, trans. Phyllis Aronoff and Howard Scott (Toronto: University of Toronto Press, 1998 [1994]), 25; The UNEF's goal was to oversee the withdrawal of British, French, and Israeli troops, as well as to monitor the Israeli-Egyptian border; Peacekeeping was not invented during the Suez Crisis. What was created was the idea that Canadians were natural born peacekeepers. See J.L. Granatstein, *Canada's Army: Waging War and Keeping the Peace*, Second Edition (Toronto: University of Toronto Press, 2011 [2002]), 342-344.

standard model for subsequent peacekeeping missions throughout the next several decades.²⁴

While Pearson's actions and rhetoric were criticized by some Canadians who felt he had betrayed the motherland with his critique of British actions during Suez, he was nonetheless internationally praised for his efforts during the Crisis, and for his role became the first Canadian to win a Nobel Peace Prize, in 1957.²⁵ Gunnar Jahn, chairman of the Nobel award committee, stated during the award ceremony that Pearson was "the man who contributed more than anyone else to save the world at that time."²⁶

Pearson was rather humble about his achievements during his Nobel Lecture, praising the UN and Secretary-General Dag Hammarskjöld for the mission's success. He also expressed caution about expecting any long-term political successes or solutions, stating, "I do not exaggerate the significance of what has been done. There is no peace in the area [the Middle East]. There is no unanimity at the United Nations about the functions and future of this [UNEF] force."²⁷ Nevertheless, the UN mission's success and adulations Pearson received convinced both Canadian politicians and the public that peacekeeping was a way for Canada to play an important role on the world stage.²⁸ Despite the evident pride expressed about Canada's efforts during the First and Second World Wars, in the half-century after the 1950s participation in UN missions allowed Canadians to define themselves more by their ability to keep the peace than to

²⁴ Ibid; Patrick James, *Canada and Conflict* (Don Mills, Ont.: Oxford University Press, 2012), 10.

²⁵ For an example of criticism "from below" see *The Globe and Mail*, 4 March 1958, which described a talk by Pearson in Flin Flon, Manitoba, where Pearson was asked to justify his decisions during the Suez Crisis.

²⁶ *The Globe and Mail*, 11 December 1957.

²⁷ Nobel Media AB. "Lester Bowles Pearson – Nobel Lecture: The Four Faces of Peace." Nobel Prize.org http://www.nobelprize.org/nobel_prizes/peace/laureates/1957/pearson-lecture.html (accessed July 28, 2014).

²⁸ Neither the government nor the military were initially enthusiastic about peacekeeping, since it was seen as a distraction from "the big show" in Germany, where Canadian troops were stationed as part of NATO forces in case of a super power conflict between the United States and the Soviet Union. See Allan English, *Understanding Military Culture*, 89.

win wars.²⁹ For several decades after Pearson's UNEF mission, Canada contributed more soldiers to peacekeeping operations than any other nation in the world.³⁰

As a middle power, peacekeeping allowed Canada to punch above its weight in international politics; it also symbolically contributed to a sense that Canada was, as Governor General Adrienne Clarkson later stated, a "peaceable kingdom."³¹ By the late 1980s, 100,000 Canadian troops had been deployed to more than thirty peacekeeping missions under UN and non-UN authority.³² It was Canadians' consistent willingness to engage in peacekeeping efforts that led Chief of the Defence Staff (CDS) General Paul Manson in 1988 to affirm: "The image of a Canadian soldier wearing his blue [UN] beret, standing watch at some lonely outpost in a strife-torn land, is part of the modern Canadian mosaic, and a proud tradition."³³ The same year, when the 1988 Nobel Peace Prize was awarded to UN peacekeepers, many Canadians felt that it was *their* prize; a notion reinforced by a *Defence White Paper* several years later which espoused that more than thirty years after Pearson's Nobel win, "Canadians could once again take pride in their contribution to peace as the Nobel Peace Prize was awarded in recognition of the work of peacekeeping personnel."³⁴ The same paper reported that both Pearson's and the 1988 prize were

²⁹ Lewis MacKenzie, "Foreword," in Horn, *The Canadian Way of War*, 7.

³⁰ Coulon, *Soldiers of Diplomacy*, x.

³¹ Bernd Horn, "Introduction," in Horn, *The Canadian Way of War*, 11; Clarkson used this term on a few occasions, such as during a memorial ceremony for four Canadian soldiers killed by American airstrikes in a friendly fire incident in Afghanistan in 2002. See Governor General, "Her Excellency the Right Honourable Adrienne Clarkson Speech on the Occasion of a Memorial Ceremony for the Fallen Soldiers of 3 PPCLI." <http://archive.gg.ca/media/doc.asp?lang=e&DocID=1056> (accessed August 6, 2014). The phrase originated in America as the title of an 1833-1834 painting, "The Peaceable Kingdom" by Quaker painter Edward Hicks. It was later used in the 1960s by Northrop Frye in reference to Canadian literary endeavours. Thereafter it became popularized after its use in the title of a 1970 book by Canadian author, historian and Toronto city councillor William Kilbourn. See William Kilbourn, "The Peaceable Kingdom Still," in Stephen Graubard, ed., *In Search of Canada* (New Brunswick, New Jersey: Transaction Publishers, 1989), 27-28.

³² Allan English, *Understanding Military Culture*, 89; Lewis MacKenzie, "Foreword," 7.

³³ Manson made this statement during a speech to the Empire Club in Toronto. Quoted in Sandra Whitworth, *Men, Militarism, & UN Peacekeeping: a Gendered Analysis* (London: Lynne Rienner Publishers, 2004), 85.

³⁴ Department of National Defence, *1994 Defence White Paper* (Ottawa: Department of National Defence, 1994), 24; This argument has been made by several authors. See, for example, Granatstein, *Who Killed the Canadian Military?*, 30; David Last, "Almost a Legacy: Canada's Contribution to Peacekeeping," in Bernd Horn, ed., *Forging a Nation: Perspectives on the Canadian Military Experience* (St. Catharines: Vanwell Publishing, 2002), 382.

an important reflection of Canada's "evolving international personality."³⁵ By 1989, peacekeeping was considered postwar Canada's major contribution to world politics, with *Canadian Defence Quarterly*, the official publication of the Canadian Army, dedicating an entire issue to peacekeeping.³⁶ In 1992, General Manson's evocative vision of the peacekeeping tradition was enshrined through the creation of a large monument to peacekeepers in Ottawa entitled *Reconciliation*. At the monument three UN peacekeepers – two men and one woman – stand with binoculars and radios, calmly observing an imaginary scene. Below, a quotation from Lester Pearson invokes history to remind viewers of Canada's pioneering role in peacekeeping.³⁷ When the monument itself was commemorated on the 1995 one dollar coin, it was evident peacekeeping had become part of the Canadian national psyche.

Scholars on both sides of the political spectrum have recognized peacekeeping's contribution to a Canadian national identity. Political scientist and feminist scholar Sandra Whitworth, for example, whose work has analyzed some of the more controversial and gendered behaviour of peacekeeping troops, acknowledged that peacekeeping was a major factor in the construction of a distinctly Canadian identity. Invoking Benedict Anderson she stated that the peacekeeping tradition and its symbolism were a crucial part of the "'imagined community' that is the nation."³⁸ On the other side of the spectrum, political and military historian Jack Granatstein claimed peacekeeping was detrimental to the Canadian military because of its encouragement of "do-goodism writ large."³⁹ Nevertheless, in his bestselling 2004 work *Who Killed the Canadian Military?* he too acknowledged the large role peacekeeping played since

³⁵ 1994 *Defence White Paper*, 24.

³⁶ David Last, "Almost a Legacy," 382. The publication is now titled the *Canadian Army Journal*.

³⁷ Pearson's quotation reads: "We need action not only to end the fighting but to make the peace ... My own government would be glad to recommend Canadian participation in such a United Nations force, a truly international peace and police force."

³⁸ Whitworth, *Men, Militarism, & UN Peacekeeping*, 34; Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (New York: Verso, 1991 [1983]), passim.

³⁹ J.L. Granatstein, *Who Killed the Canadian Military?* (Toronto: Harper Collins, 2004), 23.

1956 in, for better or worse, differentiating Canadian military efforts and identity from that of its southern neighbour.⁴⁰ Thus, while academics have interpreted its effects and meaning in different ways, there is a general consensus that peacekeeping contributed to Canadians viewing themselves as peaceful, reticent warriors whose efforts brought stability to embattled parts of the globe.⁴¹ At the end of the twentieth century, the peacekeeping tradition was one of the most prominent threads in the national tapestry.⁴² Along with the Mounties, the canoe, and visions of the great white North, peacekeeping was one of Canada's enduring "national dreams;" a symbol that expressed some of the fundamental beliefs Canadians held about their national character.⁴³

Peacekeeping Changes, Budget Cuts, and Cover-Ups

Unfortunately, just as peacekeeping became a national symbol, "peacekeeping" itself morphed into a vague and often euphemistic concept. With the dissolution of the Soviet Union by 1991, a proliferation of local ethnic and nationalist conflicts sprung up across the globe, resulting in an increased need for peacekeeping operations.⁴⁴ In 1991 there were only 11,000 UN "Blue Helmets" on eleven peacekeeping operations, but by late 1994 there were 76,000 deployed at seventeen different sites around the world.⁴⁵ What had previously been an activity largely "full of subtleties for the governments involved and a bit of romantic adventure for the participating soldiers" became one of almost metaphysical complexity.⁴⁶ UN forces in the early- to mid-1990s were expected to, among other things, intervene in civil wars, patrol dangerous areas, organize

⁴⁰ Ibid.

⁴¹ Bernd Horn, "Introduction," in *Forging a Nation*, 11.

⁴² Ibid.

⁴³ Daniel Francis, *National Dreams: Myth, Memory, and Canadian History* (Vancouver: Arsenal Pulp Press, 1997), 10.

⁴⁴ Coulon, *Soldiers of Diplomacy*, ix; Some of these conflicts began because of the Soviet Union's collapse, and others were unrelated.

⁴⁵ Ibid.

⁴⁶ Ibid., ix-x.

elections, engage with and disarm militias, help to rebuild infrastructure, and create and reinforce new borders.⁴⁷ In some instances, as in Somalia, UN peacekeepers were given mandates that allowed them to be both heavily armed and legally sanctioned in the use of force against warring parties.⁴⁸

The Pearsonian peacekeeping model that served the world well in the postwar period proved to be antiquated, and “peacekeeping” changed into something often more akin to peace building or peace enforcement.⁴⁹ The *1994 Defence White Paper* hinted at such changes when it acknowledged the “changing face of peacekeeping” and noted that the nature of UN missions “now poses far more risk to our personnel.”⁵⁰ That view was mirrored by UN Secretary-General Boutros Boutros-Ghali in his 1992 report *An Agenda for Peace*, and 1995 follow-up report, both produced for the UN Security Council. Boutros-Ghali described a “new breed of intra-state conflicts” that were “often guerrilla wars without clear front lines,” and cautioned that, “Peacekeeping today can involve constant danger.”⁵¹ His assessment of the heightened danger was reflected in casualty figures. While 400 peacekeepers were killed between 1948 and 1990, most often in accidents, in just four years between 1991 and 1995, 460 were killed, usually in combat or attacks on UN personnel.⁵² As it had done since the UN’s creation, Canada dutifully participated in numerous peacekeeping missions throughout the 1990s despite the increased danger and complexity of many operations. In late 1992, Canada had peacekeeping troops under UN authority in Cyprus, the Golan Heights, Cambodia, El Salvador, Kuwait, the Western

⁴⁷ Ibid.

⁴⁸ Ibid., 8.

⁴⁹ James, *Canada and Conflict*, 10.

⁵⁰ *1994 Defence White Paper*, 3.

⁵¹ Boutros Boutros-Ghali, *An Agenda for Peace 1995: With the New Supplement and Related UN Documents* (New York: United Nations Publications, 1995 [1992]), 8; Boutros-Ghali further elaborated on this point using statistics. In 1988, of the five UN operations in existence, only one was related to an intra-state conflict. By 1995, thirteen out of twenty-one operations were intra-state conflicts. See *ibid.*, 7-8.

⁵² Coulon, *Soldiers of Diplomacy*, x.

Sahara, Nicaragua, and the former Yugoslavia.⁵³ Moreover, while Canadian soldiers participated in harrowing missions during the 1990s, they also operated under socio-economic turmoil.

The 1990s was, in many respects, the most difficult decade for the CAF and DND since the end of the Second World War. An increased operational tempo and series of major scandals coincided with successive rounds of budget cuts running throughout the decade, leading one senior figure to retrospectively deem the 1990s “The Decade of Darkness.”⁵⁴ Both organizations struggled to weather the storm as they went from “disaster to calamity.”⁵⁵ While the decade began with a large CAF presence in Europe and a manageable number of peacekeeping operations, the situation rapidly changed after the fall of the Soviet Union ushered in a new, post-Cold War world.⁵⁶ In spite of a rising national debt crisis during the early 1990s, Canadians felt obligated to do their part once again. Beginning with the Progressive Conservative cabinet of Prime Minister Brian Mulroney, successive governments committed the CAF to a plethora of peacekeeping operations while concurrently decreasing its resources and personnel levels.⁵⁷ The first difficulty related to the Forces Reduction Program (FRP). Begun in 1991, the FRP aimed to decrease the total strength of CAF Regular Force members from approximately 89,000 to 60,000

⁵³ David Bercuson, *Significant Incident: Canada's Army, the Airborne, and the Murder in Somalia* (Toronto: McClelland & Stewart, 1996), 220-221.

⁵⁴ The term, coined in 2003 by Lieutenant-General (ret.) Al DeQuetteville, former Chief of the Air Staff, originally referred to a successive wave of budget cuts that occurred across the board throughout the 1990s, and their impact on how senior CAF/DND leadership viewed the future of operational capabilities. There was a very real sense of frustration and uncertainty amongst senior leadership regarding the ability to conduct long-term planning, as well as concerns about whether or not the CAF would be equal to the tasks requested of it, particularly given the increased operational tempo that occurred early in the decade. While the term originally referred to the budgets cuts and sense of uncertainty, it later took on a metaphorical meaning describing the many difficulties the CAF faced throughout the decade. See Allan English, “From Combat Stress to Operational Stress,” *passim*; Part of this historical background was provided to the author by Brigadier-General (ret.) Joe Sharpe via email correspondence: G.E. Sharpe, e-mail message to author, November 7, 2014; More background is also taken from G.E. Sharpe and Allan English, “The Decade of Darkness – The Experience of the Senior Leadership of the Canadian Forces in the 1990s,” paper written for the Canadian Forces Leadership Institute, 24 February 2004.

⁵⁵ Sharpe and English, “The Decade of Darkness,” 1.

⁵⁶ *Ibid.*, 3.

⁵⁷ Coulon, *Soldiers of Diplomacy*, 26; Granatstein, *Who Killed the Canadian Military?*, 127-159; Granatstein laid the blame for the many scandals of the 1990s largely on the Mulroney government, who “agreed to commitment after commitment while failing to ensure that the forces had the necessary manpower, the funds, the equipment, and the training to do the jobs they were being asked to undertake.” See *ibid.*, 159.

by the decade's end.⁵⁸ What this reduction meant for the CAF was essentially "do more with less." Budgetary cutbacks also affected equipment, something made evident during operations in subsequent years.⁵⁹

Although finances were an ongoing concern for senior leaders, inside the walls of National Defence Headquarters in Ottawa, DND and CAF officials also battled with numerous scandals that tarnished both organizations' reputation. One source of embarrassment related to sexual harassment and assault in the military. In August 1993 the *Globe and Mail* published an exposé about the harassment of female CAF members, drawing attention to the fact that more harassment claims were filed in 1992 with the Canadian Human Rights Commission against the CAF than against any other single institution.⁶⁰ That statistic was a significant concern for an institution in which women made up 11% of its 80,000 members by 1993.⁶¹ Though the CAF did not keep statistics on sexual harassment, a DND study released a few months prior to the *Globe* article stated that one in every four female soldiers reported incidents of sexual harassment, with a small number even claiming they had been raped or subjected to attempted sexual assault.⁶² One retired Major-General chalked the problem up to men's resentment toward women entering an historically male preserve, but a 1998 *Maclean's* magazine article titled "Rape in the Military," followed by two more articles later that year in which numerous former military women reported "flagrant hostility" and sexual harassment, hinted the problem went deeper than just male posturing.⁶³ Under pressure after the June 1998 exposé, CDS Maurice Baril asked

⁵⁸ 1994 *Defence White Paper*, 8.

⁵⁹ See Corporal Gregory Prodaniuk's anecdote about exchanging helmets with outgoing peacekeepers below.

⁶⁰ *The Globe and Mail*, 7 August 1993.

⁶¹ *Ibid.*

⁶² *Ibid.*; A Canadian Human Rights Tribunal had in 1989 criticized the CAF for its slow rate of gender integration, and ordered that all women be allowed to fill all military roles within the next ten years. See Granatstein, *Who Killed the Canadian Military?*, 139-148.

⁶³ *Ibid.*; Jane O'Hara, "Rape in the Military," *Maclean's*, 25 May 1998; Jane O'Hara, "Speaking Out on Sexual Assault in the Military," *Maclean's*, 1 June 1998. The May 1998 article as well as the aforementioned 1993 *Globe*

women who had been sexually assaulted to come forward and tell their story, insisting their case would be quickly and thoroughly investigated.⁶⁴ Despite Baril's admission that a problem existed, a December 1998 *Maclean's* follow-up piece, which stated that almost all thirty women who came forward to the magazine were disappointed with how their case had been handled, implied that CAF and DND leaders were more concerned with their public image than with a radical expunging of the problem.⁶⁵

The Somalia Affair

Sexual harassment in the military was a significant flashpoint throughout the decade, but above all else it was events in Belet Huen, Somalia, on 16 March 1993 that overshadowed the CAF for the remainder of the 1990s. That night, two members of the Canadian Airborne Regiment (CAR), in Somalia as part of Unified Task Force (UNITAF), a UN-sanctioned, US-led peace-enforcement contingent, viciously tortured and murdered a Somali teenager caught hiding in a portable toilet on the Canadian compound.⁶⁶ The shock of the crime was matched only by its brutality. For over two hours Master Corporal Clayton Matchee and Private Kyle Brown, unhindered by numerous witnesses who saw the crime in progress, blindfolded their prisoner, beat him repeatedly, and burned his feet with cigarettes, at several points stopping to take "trophy photos" of themselves with the victim.⁶⁷ Another CAR member later found the dying

article also tangentially mentioned some of the women having been diagnosed with PTSD, in all cases within a civilian milieu. This issue was also covered in the *Toronto Star*. See *The Toronto Star*, 11 June 1998.

⁶⁴ Jane O'Hara, "Of Rape and Justice," *Maclean's*, 14 December 1998.

⁶⁵ O'Hara, "Speaking Out."

⁶⁶ David Bercuson, *Significant Incident*, 8; Operation Deliverance, as it was known, was sanctioned by the UN Security Council under Chapter VII of the UN Charter, which authorized the dispatch of peace-enforcement troops rather than peacekeeping troops. In Somalia, their job was to impose peace on warring factions so that relief efforts and supplies could be brought into the country, which had experienced famine for months. See *ibid*, 2-3.

⁶⁷ The horrific details of this event and its surrounding circumstances have been reconstructed by several authors. See, Bercuson, *Significant Incident*, *passim*; Coulon, *Soldiers of Diplomacy*, 88-100; Donna Winslow, "The Parliamentary Inquiry into the Canadian Peace Mission in Somalia," paper presented at the fourth Workshop on "Strengthening Parliamentary Oversight of International Military Cooperation and Institutions," Brussels, Belgium,

teenager, Shidane Arone, and sounded the alarm, but Arone was declared dead as a result of injuries when taken to a medical unit. Future testimony revealed that Arone had repeatedly screamed “Canada! Canada!” shortly before his death.⁶⁸ Military police were not informed until 19 March, at which time Matchee was arrested. Perhaps finally sensing the gravity of his crime, he tried to commit suicide. He was found hanging in his cell a few hours later, alive but in a coma. He was then taken to an Ottawa hospital and subsequently declared unfit for trial on account of severe brain damage.⁶⁹ Private Brown was court-martialed, dishonourably discharged, and sentenced to five years in prison, but was released after serving less than two years.⁷⁰

Ottawa ordered a full military police investigation within three days of the 16 March crime, but details were kept hidden.⁷¹ A *Globe and Mail* article published two weeks after Arone’s murder, laconically titled “4 Soldiers Held in Somali’s Death,” revealed the duration of time and extent to which the media and public had been kept in the dark.⁷² But such secrets could not be kept indefinitely. By 20 April the Canadian Broadcasting Corporation (CBC) was the first to allege a cover-up regarding the Somali teen’s death.⁷³ The parliamentary opposition accused Minister of National Defence (MND) Kim Campbell, an aspirant to the Prime Minister’s Office, of failing to bring the matter to light sooner; a criticism that was given credence when it took until 27 April for Campbell to announce the creation of a military board of inquiry into the CAR’s activities in Somalia.⁷⁴ Worse was still to come when a Canadian military physician’s

July 12-14, 2002; Reports differ on Brown’s actual participation in the physical torture, but at the very least he was a willing accomplice. Winslow served as an academic researcher for the Somalia Inquiry.

⁶⁸ Coulon, *Soldiers of Diplomacy*, 94.

⁶⁹ *Ibid.*, 94-95.

⁷⁰ *Ibid.*, 97; Whitworth, *Men, Militarism & UN Peacekeeping*, 96.

⁷¹ Bernd Horn and Bill Bentley, *Forced to Change: Crisis and Reform in the Canadian Armed Forces* (Toronto: Dundurn Press, 2015), 48.

⁷² *The Globe and Mail*, 2 April 1993; In fact, were it not for Jim Day, a reporter for the *Pembroke Observer*, being present at the compound when the incident occurred, it seems likely the event might have come to light even later. See Winslow, “The Parliamentary Inquiry,” 6.

⁷³ Horn and Bentley, *Forced to Change*, 48.

⁷⁴ Coulon, *Soldiers of Diplomacy*, 95.

testimony revealed that less than two weeks before Arone's murder, on 4 March, a Somali was killed under suspicious circumstances when attempting to enter the Canadian's Belet Huen compound. According to the medic, the Somali man was killed execution style, with a bullet in the back before someone "finished him off" with another in the head.⁷⁵ The doctor reported being subsequently pressured to destroy his medical files related to the shooting.⁷⁶ By the end of April a media blitz began, with various outlets reporting that documents related to Somalia had repeatedly gone missing.⁷⁷ As public outrage escalated over the next few years, the magnitude of inquiries grew along with it. The flames of public anger were stoked in November 1994 when a publication ban on the "trophy" photos taken during Arone's murder was lifted, leading to the pictures' printing in newspapers across the country.⁷⁸ In 1995, a Parliamentary inquiry was created to get at the full truth, take some heat off of the Jean Chrétien Liberal government, and provide much needed transparency to the public.⁷⁹ The Commission of Inquiry into the Deployment of Canadian Forces to Somalia, itself cut short in January 1997 by MND Doug Young just before it began to investigate Arone's death and alleged cover-up attempts by DND officials, nonetheless brought forth a litany of problems.⁸⁰

⁷⁵ Ibid; Sandra Whitworth, *Men, Militarism, & UN Peacekeeping*, 91.

⁷⁶ Whitworth, *Men, Militarism & UN Peacekeeping*, 91.

⁷⁷ Winslow, "The Parliamentary Inquiry," 6; Moreover, documents requested by journalists had been altered, in some cases illegally. For more on this see Horn and Bentley, *Forced to Change*, 48-49.

⁷⁸ *The Globe and Mail*, 8 November 1994.

⁷⁹ Winslow, "The Parliamentary Inquiry," 11.

⁸⁰ The Commission's final report was tabled, in five volumes, and published in July 1997. See Commission of Inquiry into the Deployment of Canadian Forces to Somalia, *Dishonoured Legacy: The Lessons of the Somalia Affair, Report of the Commission of Inquiry into the Deployment of Canadian Forces to Somalia* (Ottawa: Canadian Government Publishing, 1997); It was revealed during the Inquiry that there was ample evidence of disciplinary problems within the CAR prior to its deployment to Somalia. As recounted by Bercuson, this included, among other things, the burning of an officer's car, an illegal discharging of fireworks, and the presence of several skinheads within the 2 Commando. Some CAR members adopted the Confederate flag as a symbol of their values and one commanding officer even performed a training jump with the flag attached to his leg. See Bercuson, *Significant Incident*, 211-214; The extent of racism and anti-social behaviour within the CAR will never be fully known, but there is a scholarly consensus that a "cancer" had grown inside at least part of it; The Liberal government truncated the Inquiry because it claimed "Canadians already knew all the important facts and ... the whole process was keeping open a wound for an unnecessarily long period of time." See Winslow, "The Parliamentary Inquiry," 15.

The Inquiry, broadcast nightly on national television, revealed deep structural problems within the CAR and at times questioned CAF/DND leadership as a whole. In an over 1500 page final report the Inquiry spotlighted numerous disciplinary issues within the 2 Commando battalion prior to its deployment: “Several witnesses testified that members of the CAR ... among other things, misused pyrotechnics, ammunition, and weapons; engaged in antisocial activities ... and abused Red Cross workers in CFB Petawawa.”⁸¹ The “most serious and alarming” sign of trouble was the burning of the unit orderly sergeant’s car; a crime which led to no charges.⁸² Matters were made worse when two disturbing videos surfaced. The first, aired in early 1994, showed 2 Commando members in Somalia making several racist comments.⁸³ A year later, the CBC aired a homemade video of 1 Commando hazing rituals from 1992 that included verbal abuse and extreme degradation, such as soldiers being forced to eat feces.⁸⁴ On 19 January 1995 prominent CBC political commentator Rex Murphy’s *Point of View* program highlighted not just the “trophy photos” taken during Arone’s murder, but also video released a day earlier, which showed the lone black member of a unit being tied to a tree and then forced to crawl on all fours with “I ♥ KKK” written on his back.⁸⁵ Murphy ended his segment by stating that the Somalia Affair, as it became known, cast a “pall of hypocrisy” over Canadians’ “much-trumpeted image

⁸¹ *Dishonoured Legacy*, Vol. 3, 681.

⁸² Ibid.

⁸³ Horn and Bentley, *Forced to Change*, 48.

⁸⁴ Bercuson, *Significant Incident*, 216, 241; For a brief but excellent analysis of the role of masculine posturing in the Affair, see Jackson, *One of the Boys*, 225-226.

⁸⁵ “Rex Murphy on the Somalia Affair: ‘Bloody and Contemptuous Images,’” *The National*, Canadian Broadcasting Corporation Digital Archives (Toronto: CBC, January 19, 1995), <http://www.cbc.ca/archives/entry/rex-murphy-on-the-somalia-affair-bloody-and-contemptuous-images> (accessed July 27, 2014); Videos which contained the damning evidence were first obtained by Scott Taylor, editor of *Esprit de Corps* magazine. Ironically, his plan was to show the Canadian public the adverse conditions the paratroops had been exposed to and the humanitarian work they had performed. The media’s airing of the segments which contained racist remarks ended up taking the lion’s share of attention. This was perhaps unsurprising, given that in one video, a CAR member was taped during the Somalia operation saying that they “ain’t killed enough niggers yet.” See James Davis, *The Sharp End*, 260; Sandra Whitworth, *Men, Militarism & UN Peacekeeping*, 93.

as peacekeepers.”⁸⁶ An equally powerful statement of the Somalia Affair’s effects was provided by the Inquiry when it stated that, “certain events transpired in Somalia that impugned the reputations of various individuals, Canada’s military, and the nation itself.”⁸⁷

The Somalia Affair, dubbed “Canada’s national shame,” sent ripple effects across all of Canadian society.⁸⁸ Canadians expressed disgust at what they saw as a tarnishing of the country’s hard-earned reputation as the foremost peacekeeping nation on earth, and one with a proud military tradition.⁸⁹ In the midst of the crisis Prime Minister Brian Mulroney was forced to respond to embarrassing statements, such as those made by Haitian Prime Minister Marc Bazin, that Canadian peacekeepers were “a pack of Nazis.”⁹⁰ The Affair was also the catalyst for several ignominious “firsts:” Matchee’s crime was the first time that any Canadian soldier had been charged with torture or murder during a UN operation.⁹¹ Although the Commission of Inquiry placed much of the blame at the CAF/DND leadership level, public outcry and media pressure, especially over the images of Arone’s torture, caused a defensive and reactionary posture by DND officials that took aim at the CAF’s lower ranks.⁹² A subsequent “cover your ass” approach developed in both organizations, with leaders blaming subordinates, who in turn passed the blame further down the chain of command to their subordinates.⁹³ Identification of the entire CAR with antisocial behaviour and Arone’s murder, instead of the smaller group of soldiers

⁸⁶ “Rex Murphy on the Somalia Affair;” It is important to note that Canada was not the only nation which had soldiers who violated proper rules of conduct in Somalia. The Italians, Belgians, and Americans, among others, also had similar incidents occur under their watch. See Coulon, *Soldiers of Diplomacy*, 98-99.

⁸⁷ *Dishonoured Legacy*, Vol. 1, xxx.

⁸⁸ Winslow, “The Parliamentary Inquiry,” 7.

⁸⁹ Coulon, *Soldiers of Diplomacy*, 89; This was not the first time that Canadian soldiers had been charged with homicide, as there had been three prior homicide trials in Germany involving Canadians. But the nature of the crime, its brutality, and the circumstances – Canadians soldiers sent to provide humanitarian aid and defense for the Somali populace murdering a teenager ostensibly under their guardianship – made the situation uniquely explosive. See *The Globe and Mail*, 2 April 1993.

⁹⁰ *The Globe and Mail*, 20 May 1993.

⁹¹ Ibid.

⁹² Winslow, “The Parliamentary Inquiry,” 21.

⁹³ Carol Off, *The Ghosts of Medak Pocket*, 233-234; Bercuson, *Significant Incident*, vi.

responsible for it, led MND David Collenette to decide upon disbanding the whole Regiment in March 1995.⁹⁴ Given the timing and circumstances, Collenette's actions were seen by some as a "political expedient to take the heat off the Forces as a whole."⁹⁵ Louise Frechette, Deputy Minister of National Defence acknowledged as much when she called the Regiment's dissolution a "political decision to change the conversation."⁹⁶ The CAR's disbanding was the first instance of a Canadian regiment's dissolution under disgraceful circumstances.⁹⁷

Public reactions against events in Somalia were consistently strong from 1993-1997. The contradiction between Canadians' usually honourable character as humanitarian peacekeepers, and Arone's torture and murder, tainted the entire CAF in much of the public's mind.⁹⁸ Anger took the form of soldiers being spat on in public, and in some cases CAR soldiers' children and spouses being harassed.⁹⁹ At one point, public backlash and media pressure were so strong that a CANFORGEN order – a Canadian Forces General Order from the Chief of the Defence Staff to all branches/members of the CAF – advised CAF members not to wear their uniforms to and from work, for fear of the sight of a man or woman in uniform upsetting the public.¹⁰⁰ As politicians, military leaders, and the public distanced themselves from the Somalia Affair, a sense of distrust developed between civilians and soldiers. Canadians simply could not reconcile displays of racism, brutality, and injustice with views of the "peaceable kingdom" that pervaded the national consciousness.

⁹⁴ Collenette himself later resigned in October 1996, with some commentators feeling that although his resignation was unrelated to the Inquiry, it was a convenient way to "let go of a very hot potato." Winslow, "The Parliamentary Inquiry," 12.

⁹⁵ James, *The Sharp End*, 264.

⁹⁶ Quoted in Horn and Bentley, *Forced to Change*, 50.

⁹⁷ Bercuson, *Significant Incident*, 130.

⁹⁸ Winslow, "The Parliamentary Inquiry," 6.

⁹⁹ *Ibid.*, 7; This claim, mentioned by Winslow, is supported by anecdotal evidence in James Davis' *The Sharp End*: "In the schools, children whose fathers were in the Regiment were teased and taunted. They had to go home and ask their fathers if they really did those things ... The wives, who loved the regiment as much as their men, were even more deeply hurt ... The wives were now isolated and unable to fight back against the pain and disgrace forced on their husbands." See Davis, *The Sharp End*, 263.

¹⁰⁰ Westholm interview; James, *Canada and Conflict*, 59-60.

Sergeant James Davis, a CAR veteran who participated in peacekeeping missions in the former Yugoslavia and Rwanda during the 1990s, recalled the fallout from Arone's murder and the hazing videos in his 1997 memoir *The Sharp End*: "Immediately we were all branded as racists. This was news to the blacks, Asians, and Native Canadians serving in the Regiment."¹⁰¹ Davis admitted there were "some bad characters" in the CAR during the early 1990s, but affirmed that they were just "a couple of double-y-chromosome types" exclusively in the 2 Commando unit, the unit from which Matchee and Brown stemmed.¹⁰² Regarding hazing rituals, Davis wrote that the only hazing which occurred in his unit, 3 Commando, involved "new guys running down to the village and buying a case of beer."¹⁰³ Davis, along with other former CAR members, lamented the public and politicians' inability to recognize the Regiment's predominantly honourable nature and its good deeds performed on numerous peacekeeping missions. Particular anger was directed at MND David Collenette: "The minister didn't realize the extent of what he had done to the soldiers, their families and the community ... Because he never apologized to the members of the unit that were untainted by scandal, about ninety-nine percent of us, for the pain this [the CAR's disbanding] would cause, he branded all of us as dishonourable murderers and rebels. His failure to separate the bad from the much larger good left us all painted by the same brush."¹⁰⁴ Retired Master Warrant Officer Barry Westholm agreed with the spirit of Davis' assessment, calling the Somalia Inquiry and disbanding of the Regiment "a real disaster" for morale.¹⁰⁵

¹⁰¹ Davis, *The Sharp End*, 260.

¹⁰² Ibid; The Inquiry and scholarly works on the Somalia Affair concluded that although there were leadership and disciplinary problems within the CAR, the incidents which caused public outrage were indeed limited to the 2 Commando, though given the role of the 1 Commando in the hazing rituals as well that seems doubtful.

¹⁰³ Ibid.

¹⁰⁴ Ibid., 263.

¹⁰⁵ Westholm interview.

Although politicians, military members, and the public argued over the Somalia Affair's root causes, a consensus nonetheless developed that Shidane Arone's murder was a defining moment for the CAF and Canadian society.¹⁰⁶ Scholars and journalists, also divided on the Affair's causes, agreed that Somalia cast a far-reaching shadow, particularly over the CAF. Military historian David Bercuson called Somalia "the deepest crisis of confidence in the history of the Canadian Armed Forces."¹⁰⁷ Journalist Carol Off described Somalia as the "worst peacetime crisis in Canadian military history."¹⁰⁸ Sandra Whitworth argued that Somalia forced Canadians into a type of cultural reflection, similar to how the My Lai Massacre perpetrated by US soldiers during the Vietnam War shocked American sensibilities.¹⁰⁹

But while the Somalia Affair laid bare perceived problems within the CAF and alarmed the Canadian public, retrospectively it was evident that Somalia and its aftershocks *concealed* as much as they *revealed*. Specifically, the immense attention Somalia received, combined with a subsequent desire amongst government and military officials to distance themselves from any potential scandal, caused several other peacekeeping operations to go largely unnoticed.¹¹⁰ Still mired in a Cold War mindset and unused to criticism or scrutiny, CAF and DND leaders "did what they had always done: simply ignore the noise in the expectation that it would go away."¹¹¹ In military terminology, they "bunkered." Colonel John Calvin recalled his soldiers returning

¹⁰⁶ Bercuson, Granatstein, and others on the "right" blamed budget cuts and a move away from traditional military preparedness, value, and operations, while those on the "left," such as Sandra Whitworth, saw Somalia more as the outcome of a "crisis of legitimacy" and "crisis of masculinity" that occurred when militaries, driven by hyper-masculine goals and attitudes, were forced to adopt a more "feminine" role as peacekeepers. Cf. Bercuson, *Significant Incident*, 238-239; Granatstein, *Who Killed the Canadian Military?*, 148; Whitworth, *Men, Militarism & UN Peacekeeping*, passim, esp. 16.

¹⁰⁷ Bercuson, *Significant Incident*, 13.

¹⁰⁸ Carol Off, *The Ghosts of Medak Pocket*, 96.

¹⁰⁹ Whitworth, *Men, Militarism & UN Peacekeeping*, 108.

¹¹⁰ Whitworth and others have noted how Arone's murder, and other prominent events such as the 1993 dragging of American soldiers' bodies through the streets of Mogadishu after a failed attempt to kill faction leader Mohamed Farrah Aidid, led to a "Somalia syndrome." Normally enthusiastic troop-contributing countries such as the United States and Canada were far more reluctant to participate in the "new" UN operations in the wake of such events. See Whitworth, *Men, Militarism & UN Peacekeeping*, 41.

¹¹¹ Horn and Bentley, *Forced to Change*, 24.

from Croatia in 1993 and feeling the great weight of the Somalia Affair: “When we came home in October of 1993, Somalia was just breaking and the focus was all on what had happened with that particular tour. I think it’s fair to say that for the next two years Somalia consumed most of the focus of the public’s attention on the military, and all of the other things that had happened, including our tour, were cast into the background.”¹¹² Unfortunately, as the media and public focused on Somalia, Canadian troops experienced the changing face of peacekeeping across the globe, and in numerous cases returned home traumatized by the danger faced and atrocities witnessed. But in the divided climate of the time their difficulties were swept under the socio-political rug by CAF/DND leaders unwilling to risk anymore scandal and a historically low civilian approval of the nation’s military.

The New Face of Peacekeeping

Somalia was one of several UN missions Canada contributed to during the 1990s which fell outside of traditional peacekeeping operations. Many of the “new” UN operations forced peacekeepers to confront an entirely different type of mission than they had trained for or expected. With the Soviet Union’s dissolution, a series of ethnic civil wars, retrospectively termed the Yugoslav Wars, occurred within the former Socialist Federal Republic of Yugoslavia. As the Yugoslav National Army (JNA) fought to retake territory lost after the secession of its former constituent republics, both military and civilian casualties mounted. In late 1991, UN envoy and former American Secretary of State Cyrus Vance proposed to Serb and Croat forces the establishment of a peacekeeping force in Croat territories under Serb control.¹¹³ Both sides accepted, and on 21 February 1992 the UN Security Council authorized the creation of

¹¹²John Wood, “Jim Calvin: Colonel,” in *The Chance of War*, 116.

¹¹³Coulon, *Soldiers of Diplomacy*, 113.

UNPROFOR, a force consisting of 15,000 UN Blue Helmets.¹¹⁴ The UNPROFOR was thus deployed to three regions of Croatia – all designated United Nations Protected Areas (UNPAs). The force’s mission was, among other things, to ensure the withdrawal of JNA troops from all Croat territory, monitor demilitarized zones, ensure the protection of civilians, and facilitate the return of displaced persons.¹¹⁵ All of these tasks were to be accomplished as a neutral party, with the belligerents’ consent, and without the use of force.¹¹⁶ Canada, which initially contributed an infantry battalion of 900 troops and a combat engineering unit in March 1992, rotated thousands of soldiers through the UNPROFOR and subsequent missions, “leaving hardly a Canadian soldier who had not served at least once in the former Yugoslavia.”¹¹⁷

Despite UN presence, throughout the UNPROFOR’s existence and subsequent UN/NATO operations, nascent national armies and paramilitary forces fought against neighbouring states, ethnic militias, and local warlords, with all sides perpetrating ethnic cleansing at various points over the decade.¹¹⁸ The level of violence employed to expel or eradicate perceived enemies was “on a scale not seen since World War II.”¹¹⁹ Canadian peacekeepers, with very little peace in the Balkans to keep, found themselves in a morass where traditional, linear missions were no guide. On the surface, the mission resembled previous operations like Cyprus, with peacekeepers wearing blue helmets and riding in painted “UN”

¹¹⁴ Ibid.

¹¹⁵ Ibid; Department of Public Information, United Nations, “Former Yugoslavia – UNPROFOR.” UN.org . http://www.un.org/en/peacekeeping/missions/past/unprof_b.htm (accessed March 21, 2015).

¹¹⁶ Coulon, *Soldiers of Diplomacy*, 114.

¹¹⁷ Off, *Ghost of the Medak Pocket*, 63; Nearly 9000 CAF members served in the Balkans between 1991 and 1995 alone.

¹¹⁸ Granatstein and Oliver, *The Oxford Companion to Canadian Military History*, 259-260.

¹¹⁹ Ibid., 260.

vehicles. But unlike in Cyprus, Canadian peacekeepers delivered humanitarian aid while armed, deployed anti-tank vehicles, and at times used snipers to kill belligerents.¹²⁰

Corporal Gregory Prodaniuk was just twenty-one-years-old and only recently completed his training as an infantry soldier when he deployed to Croatia as part of 1 Royal Canadian Regiment in 1994. Prior to deployment, his unit was given training appropriate for “normal” peacekeeping operations. He summarized his training in the following manner: “Man an OP [observation post]; write a log; come to a riot; search a building for weapons.”¹²¹ Nevertheless, aware through word-of-mouth channels about what Canadian soldiers had experienced thus far in the former Yugoslavia, Prodaniuk sensed he was entering a mission “irregular to the peacekeeping experience up to that point.”¹²² He recalled:

When we got over there [to Croatia] it sort of started immediately. We got into theatre and we had to stand in line and exchange equipment with the guys that were coming out. And you noticed the guys that were coming out looked pretty bad, pretty haggard. They definitely didn’t look like ... the sort of clean cut Cyprus pictures that you’d seen. You saw guys that hadn’t cleaned [themselves] in a few days, had bags under their eyes. Their equipment was all dirty ... At that point we didn’t even have our own helmets so we were exchanging helmets. So we were looking for a guy that had the same head size ... to grab a helmet off him. It was a very sort of weird way to be introduced into theatre, and as we’re getting off a certain commercial airline we can hear the [artillery] shelling going on in the background.¹²³

Prodaniuk’s unit spent most of its time isolated across various outposts in a zone of separation between Serbs and Croats. Much of their time was also spent wondering if and when the situation might erupt, while occasionally being shot at, shelled by artillery, and coming upon “a lot of gruesome events that had taken place just before we got there.”¹²⁴ As his tour

¹²⁰ Sean Maloney, “In the Service of Forward Security: Peacekeeping, Stabilization, and the Canadian Way of War,” in Horn, *The Canadian Way of War*, 314-315.

¹²¹ Prodaniuk, Gregory. Interview by author. Telephone. Toronto, August 13, 2014.

¹²² Ibid.

¹²³ Ibid.

¹²⁴ Ibid.

progressed things started to “ramp up.” NATO planes bombed around them. In several instances he was sent with only two or three comrades to inspect Serb or Croat-held buildings for weapons and explosives. In groups often numbering fifty or more, both belligerent forces were unhappy about the UN presence and employed posturing and threats to intimidate Canadian forces. Their tactics included, among other things, “cocking weapons, putting it at your head, that kind of stuff.”¹²⁵ Prodaniuk characterized the mission as a “really messed up police operation,” stating matter-of-factly that “it really wasn’t something we trained for.” Like numerous comrades, he felt at a loss to grasp the reality of what his “peacekeeping” duties entailed: “That disconnect between what you *thought* you were going to be doing, and what you ended up doing, was pretty profound.”¹²⁶

The biggest testament to how peacekeeping had changed came in September 1993, when members of the Second Battalion of the Princess Patricia’s Canadian Light Infantry (2PPCLI) were involved in heavy fighting with Croatian forces during what was later termed the Battle of Medak Pocket.¹²⁷ That month, Croatian forces attacked Serb-held territory in Sector South, one of the UN’s Protected Areas. After five days of battle, a UN-brokered ceasefire led to 875 soldiers from 2PPCLI being interposed between the warring parties.¹²⁸ Their mandate was to supervise the removal of Croat troops back to their original lines, and likewise to remove Serb troops from a “pocket” that formed during the Croatian offensive.¹²⁹ As the Canadian peacekeepers took up positions, local Croat forces refused to let them enter the area and fired on

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Off, *The Ghosts of Medak Pocket*, passim; Granatstein and Oliver, *The Oxford Companion*, 257-258; National Defence and the Canadian Armed Forces, “The Battle of Medak Pocket” Government of Canada. <http://www.forces.gc.ca/en/news/article.page?doc=the-battle-of-medak-pocket/hljg3bso> (accessed March 22, 2015). The story of Medak, and the Yugoslav Wars, were well covered in Off’s 2004 book.

¹²⁸ Ibid; That contingent also included some French troops.

¹²⁹ Granatstein and Oliver, *The Oxford Companion*, 258.

their UN vehicles. A fifteen-hour firefight ensued, during which four Canadians were wounded and an estimated twenty-seven Croats killed, with many more wounded.¹³⁰

Worse was still to come. After negotiations brought fighting to a close, Canadian peacekeepers moved into the Croats' previously held areas to find a plethora of gruesome sights. In numerous villages Serbian civilians had been murdered, and there were many signs of rape, livestock destruction, and local wells being poisoned. Sergeant-Major Mike Spellen, a member of 2PPCLI's Delta Company assigned to a "sweep team" searching the area, found a wheelbarrow in the middle of a swamp. Thinking it a strange sight, he investigated further and found the body of an eighty-four-year-old woman who had been shot at least six times.¹³¹ Warrant Officer Matt Stopford recalled seeing a Croatian sergeant throw a "bundle" into a burning house while dancing around with a bloody pair of child's training underwear on his head. Stopford realized after a few moments that the bundle was a dead child who had been thrown into the burning building.¹³² Echoing Stopford's experience, Master Corporal Jordie Yeo lamented: "The number of times that I saw graves that were only three or four feet long was too many."¹³³ Traumatic sights were common in the aftermath of the Medak Pocket battle, and were witnessed by numerous Canadian peacekeepers in the former Yugoslavia throughout the 1990s. In an interview, Mike Spellen stated there was a pervasive mental and physical exhaustion amongst his comrades, further exacerbated by "being aware that there are atrocities going on around you, [and] seeing some of those atrocities."¹³⁴ The UNPROFOR's inability to prevent civilian deaths led Fred Doucette, a Canadian UN Military Observer in Bosnia in 1995, to argue

¹³⁰ Granatstein and Oliver, *The Oxford Companion*, 258; The casualty figures are estimated because the Croatian government subsequently denied that anyone died, or that the battle even took place.

¹³¹ Off, *The Ghosts of Medak Pocket*, 215.

¹³² John Wood, "Matt Stopford: Warrant Officer" in *The Chance of War*, 135; For Stopford and others, the worst part of seeing such atrocities was that they were forced to watch without being able to intervene.

¹³³ John Wood, "Jordie Yeo: Master Corporal," in *The Chance of War*, 222.

¹³⁴ Spellen, Mike. Interview by author. Telephone. Toronto, December 1, 2014.

that the UNPROFOR was as useless as “eunuchs in a whorehouse.”¹³⁵ The myriad mental and physical challenges peacekeeping presented took a heavy toll on Canadian soldiers’ minds, but recognition of that fact was slow to come because of military leaders’ willful blindness about war-related mental disorder.

Early Signs (of PTSD)

From the beginning of the UNPROFOR and other non-standard peacekeeping missions during the early 1990s, there were whispers within and outside military circles that the “new” peacekeeping significantly impacted its participants. The first publicly visible sign of the aftermath came in September 1993 when a twenty-six-year-old member of 2PPCLI was found dead in full uniform after shooting himself in his apartment.¹³⁶ His suicide came shortly after returning from peacekeeping in Croatia. Throughout the 1990s there were widespread rumours and stories about suicides and attempted suicides by peacekeepers after their return from the former Yugoslavia, but higher authorities made a concerted effort to downplay the problem’s extent.¹³⁷ A soldier who fought at Medak recalled his superiors telling him he was the only one from his unit with mental health problems.¹³⁸ In addition to suicides, there were a number of soldiers who took up heavy drinking, in large part to rationalize their experiences or drown out nightmares. Many troops felt they simply could not relate what happened, or their feelings about it, to comrades or family who were not with them in theatre.¹³⁹ It took a number of years before the prevalence of health issues amongst peacekeepers was known to both the public and soldiers themselves.

¹³⁵ Doucette, *Empty Casing*, 86.

¹³⁶ *The Globe and Mail*, 6 December 1993.

¹³⁷ Off, *The Ghosts of Medak Pocket*, 256-257.

¹³⁸ *Ibid.*, 257.

¹³⁹ *Ibid.*, 256.

Although CAF leaders and medical officers during the early 1990s were aware of the effects of combat stress on soldiers, due to peacekeeping's traditionally lower tempo and ostensibly less stressful character, authorities initially made a strict separation between the stress of "war" and difficulties encountered in "military operations other than war."¹⁴⁰ Peacekeeping operations, not held in the same high regard among military members as war tours, were viewed through the prism of Cold War UN missions, and as such, deemed largely mundane in character.¹⁴¹ It was for that reason the CAF sent psychiatric resident Greg Passey, a psychiatric nurse, and a social worker with the Canadian Naval Task Group during the Gulf War in 1991, but did not send a team during the initial stages of the UNPROFOR mission a year later.¹⁴² A 1991 *Globe and Mail* article written in the midst of the Gulf conflict optimistically stated that rather than being treated as cowards or malingerers as they were in the past, CAF personnel suffering from combat stress were "treated as victims of a 'combat-related, critical incident, stress event.'"¹⁴³ Lieutenant-Colonel James Jamieson, Director of Social-Development Services for the Surgeon-General in Ottawa, affirmed that "The whole philosophy [toward psychological difficulties from war] has changed," and that the military no longer considered traumatized soldiers to be "cowardly or crazy."¹⁴⁴ Captain Judith Pinch, a social worker employed at Canadian military headquarters in Bahrain, mirrored Jamieson's optimism, painting a brighter picture for soldiers: "They can show their feelings now ... They don't have to be always appear

¹⁴⁰ Allan English, "From Combat Stress to Operational Stress," 11.

¹⁴¹ Ibid; In the US context, peacekeeping operations were judged even at the highest command levels as something emasculating in character, with the Chairman of the Joint Chiefs of Staff declaring that "real men don't do moot-wah." See *ibid*.

¹⁴² Rhonda Birenbaum, "Peacekeeping Stress Prompts New Approaches to Mental-Health Issues in Canadian Military," *Canadian Medical Association Journal* 151, no. 10 (1994): 1485.

¹⁴³ *The Globe and Mail*, 16 February 1991; The combat-stress-intervention team was a new concept for the military, and due to the fact that Canada had not been at war in a long time (since Korea), the Gulf War was the first chance to test its efficacy.

¹⁴⁴ Ibid.

brave and strong and keep their feelings to themselves. It's not what it used to be, that's for sure.”¹⁴⁵

But war was regarded as qualitatively different from peacekeeping, and there were no similar articles describing a new day for traumatized peacekeepers when Canadians were sent to Croatia and Bosnia in 1992. The idea that Canadian soldiers could become psychologically debilitated from peacekeeping duty went against decades of understanding about war trauma and common sense approaches to military operations. The distinction between war and peacekeeping's effects were neatly encapsulated in the terms themselves: “Combat Stress Reaction,” the 1990's intellectual successor to “shell shock,” described the effects that occurred as a result of *combat*, while peacekeeping, due to its ostensibly *peaceful* nature, seemed to preclude any instances of trauma or psychological disorders.¹⁴⁶ Thus, throughout the early- to mid-1990s Canadian military leaders were in a state of “blissful ignorance” regarding peacekeeping trauma.¹⁴⁷ In their 2015 book about CAF leadership culture during the 1990s, Bernd Horn and Bill Bentley described the situation thus: “Due to their myopic focus and isolation, as well as their anti-intellectual mindset, the senior leadership of the DND and the CAF had been unable to anticipate, adapt, or change to the myriad of changes that swept over Canadian society and the globe.”¹⁴⁸

One of the few voices penetrating preconceived notions of war trauma in the early 1990s was that of naval Lieutenant-Commander Greg Passey.¹⁴⁹ Passey, a psychiatric resident (from

¹⁴⁵ Ibid.

¹⁴⁶ English, “From Combat Stress to Operational Stress,” 11.

¹⁴⁷ Ibid.

¹⁴⁸ Horn and Bentley, *Forced to Change*, 37.

¹⁴⁹ The Royal Canadian Navy at that time was still called Maritime Command; In the civilian realm it is worth mentioning that psychologist Dr. A. Lynne Beal examined PTSD symptoms in prisoners of war and combat veterans of the Dieppe Raid. Like Passey's work, her study was few and far between in Canada during the 1990s. See A. Lynne Beal, “Post-Traumatic Stress Disorder in Prisoners of War and Combat Veterans of the Dieppe Raid: a 50-Year Follow-up,” *Canadian Journal of Psychiatry* 40, no. 4 (1995): 177-184; Tom Spears, “Psychologic Scars

the University of British Columbia) sent to the Gulf War in 1991, was the first, along with his supervisor David Crockett, to quantify the psychological impact of peacekeeping on Canadian soldiers.¹⁵⁰ In 1992-1993, Passey, who made weekly visits to CFB Chilliwack to help medical staff treat CAF psychiatric patients, discovered a number of soldiers displaying signs of PTSD.¹⁵¹ He had become familiar with trauma symptoms a few years earlier while in charge of a hospital in the small community of Masset, British Columbia. During a 2015 conversation he recalled a particular case of a two-year-old child dying after being burned in a house fire, and the devastating impact the event had on the child's family.¹⁵² Passey was also an avid reader of military history and from his readings was familiar with shell shock and battle exhaustion.¹⁵³ Lastly, at a trauma studies conference in Amsterdam in June 1992 he discussed the subject with several researchers from America, and from hearing about a particular study on trauma in Russian veterans from the Soviet-Afghan War he became convinced PTSD could also stem from non-traditional combat and/or operations resembling war.¹⁵⁴

Thus, seeing common symptom patterns in Canadian peacekeepers, Passey commissioned a study of Regular Force soldiers and Reservists from three peacekeeping regiments: Combat Engineers in Chilliwack; troops from the Royal Canadian Regiment in Gagetown, New Brunswick; and members of PPCLI in Winnipeg.¹⁵⁵ Study participants filled out confidential questionnaires that measured their stress and depression level, in order to determine the prevalence of debilitating psychological symptoms among former peacekeepers. The results,

Remain 50 Years After Dieppe Raid, Study of Canadian Veterans Finds," *Canadian Medical Association Journal*, 153, no. 9 (1995): 1324-1326.

¹⁵⁰ Rhonda Birenbaum, "Peacekeeping Stress Prompts New Approaches," 1485; Passey was also a former General Duties Medical Officer. Passey and Crockett's study was the first of its kind in the world.

¹⁵¹ CFB Chilliwack officially closed in 1997.

¹⁵² Passey, Greg. Interview by author. Telephone. Grimsby, Ontario, August 6, 2015.

¹⁵³ Ibid; Passey stated that one of the books which had an impact on his conceptualizations of trauma was Copp and McAndrew's 1990 book *Battle Exhaustion*, cited in earlier chapters.

¹⁵⁴ Ibid.

¹⁵⁵ Birenbaum, "Peacekeeping Stress Prompts New Approaches," 1485.

published in the *Winnipeg Free Press* and *Globe and Mail* in December 1993, confirmed Passey's suspicions: One Canadian peacekeeper in nine (11%) was returning from the former Yugoslavia suffering from combat stress.¹⁵⁶ Amongst the many symptoms soldiers reported, the most prevalent were anxiety or panic attacks, irritability, difficulty falling asleep or staying asleep, diminished interest in work, family or friends, and "curtailed emotions."¹⁵⁷ A twenty-five-year-old soldier stationed in Winnipeg agreed with the study's conclusion, stating, "I'm a different person. I have changed for the rest of my life. Over there you're staring at dead kids and starving people and little old ladies who run beside your vehicle so they won't get hit by snipers."¹⁵⁸ Passey ominously inferred that as time passed and new symptoms such as alcoholism and flashbacks manifested, the number of peacekeepers experiencing psychological difficulties might increase.¹⁵⁹

Passey and Crockett's study was the first to demonstrate something unique about the CAF's historical experience with psychological trauma. They espoused that, contrary to contemporary beliefs about combat stress and trauma, peacekeeping missions also exposed soldiers to overwhelmingly traumatic experiences.¹⁶⁰ In a 1994 *Canadian Medical Association Journal* article, Passey further explained the implications of his 1993 study. He espoused that, "our people [peacekeepers] are under horrendous stress," and that, although "[p]eacekeeping may not be more stressful than battle ... it is certainly more stressful than anyone thought."¹⁶¹ Unlike war, which often had tangible goals, ways to measure the success or failure of a mission, and clearly defined sides, peacekeeping "success" was judged according to more Spartan

¹⁵⁶ *The Globe and Mail*, 6 December 1993.

¹⁵⁷ Birenbaum, "Peacekeeping Stress Prompts New Approaches," 1485.

¹⁵⁸ *Globe and Mail*, 6 December 1993.

¹⁵⁹ *Ibid.*

¹⁶⁰ Off, *The Ghosts of Medak Pocket*, 245.

¹⁶¹ Birenbaum, "Peacekeeping Stress Prompts New Approaches," 1485.

considerations like “how many people got food or were not killed.”¹⁶² Peacekeeping stresses and trauma were often different in kind from combat stresses, but the effect was similar. Passey and Crockett’s study was the first powerful piece of evidence that there *was* such a thing as peacekeeping trauma, and also helped confirm that the word “peacekeeping” was in many cases a euphemism for something more menacing.

On the surface, the CAF leadership’s response to Passey and Crockett’s study, and trauma in general, was one of action. In 1991 the CAF had taken a proactive approach to combat stress during the Gulf War when it sent Passey and the rest of his team to educate personnel about the stresses of war and help them deal with separation from loved ones.¹⁶³ A team of specialists were also on hand to provide “Critical Incident Stress Debriefing (CISD),” a process developed in the 1980s, initially targeting emergency response workers, to help them deal with acute stress and traumatic incidents.¹⁶⁴ Beginning in the 1990s, in part due to the efforts of social worker Lieutenant-Colonel Rick McLellan, who likewise saw a need to pay more attention to intense stress’ effect on troops, the CAF implemented CISD.¹⁶⁵ CISD was one of the military’s methods for preventing long-term psychological impacts in soldiers exposed to a “critical incident,” an event defined as “outside the range of normal experience that is sudden, unusual, and unexpected, disrupts one’s sense of control, involves the perception of a threat to life, and may include elements of physical or emotional loss.”¹⁶⁶ CISD’s purpose was not professional

¹⁶² Ibid., 1486.

¹⁶³ *The Globe and Mail*, 16 February 1991.

¹⁶⁴ Developed by Dr. Jeffrey Mitchell in the early 1980s, the approach was first laid out in a 1983 article. See J.T. Mitchell, “When Disaster Strikes ... The Critical Incident Stress Debriefing Process,” *Journal of Emergency Medical Services* 8, no. 1 (1983): 36-39; CISD seems to have been first utilized by the CAF in 1993 after a C-130 Hercules transport plane crashed at CFB Wainwright (Alberta) on 22 July 1993. See Testimony of Captain John Organ, *Croatia Board of Inquiry*, September 24, 1999, vol. XIII, 6; For media coverage of the crash see *The Globe and Mail*, 23 July 1993.

¹⁶⁵ Passey interview.

¹⁶⁶ This definition was taken in large part from the DSM-III, which defined a traumatic event as one “outside the range of usual human experience” and one that likewise involved a threat to the person, such as war, torture, rape, or natural disaster. See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*,

counseling, but rather “to provide a safe opportunity [for soldiers] to deal with reactions to a stressful traumatic event.”¹⁶⁷ Ideally taking place within a few days after the event, the goal of Critical Incident Stress (CIS) teams, according to Lieutenant-Colonel Jamieson, was to deal with traumatized troops as quickly as possible and “as close as possible to [the] event.”¹⁶⁸ Soldiers were encouraged to express their feelings and emotions, and reassured by the CIS team their reactions were “experienced by normal people following an abnormal event.”¹⁶⁹

While based on good intentions, CISD and information about critical incidents were inconsistently applied during the early 1990s and went up against a closed culture that taught soldiers to spurn outsiders, especially “suits” who did not understand life at the front line. Mike Spellman could not recall any conversations about stress or trauma prior to and during his time in theatre. He espoused that before Croatia there were “no concerns of that [PTSD] whatsoever,” and that he did not even know what “PTSD” meant.¹⁷⁰ Andrew Godin remembered a CIS team arriving from Ottawa during the tail end of his 1992 Croatia tour. They asked Godin and others “a bunch of questions about what we did and saw during the tour,” but because the CIS team had no frontline soldiers on it, “getting answers out of us was like pulling teeth from a chicken.”¹⁷¹ James Davis wrote that he and his comrades instituted an informal type of CIS therapy: “If someone seemed to be walking too fine a line, the Warrant [Officer] would have a couple of the

Third Edition, 236-239; For an example of information provided by the CAF to its troops about CIS see Department of National Defence, Directorate of Medical Policy, *Preparing for Critical Incident Stress* (Ottawa: Directorate of Medical Policy, 2000); Greg Passey stated during an interview that McLellan was one of the key persons behind the push to introduce CISD and pay more attention to stress among troops.

¹⁶⁷ Department of National Defence, *Preparing for Critical Incident Stress*, 9; By the end of the 1990s CISD was heavily utilized in civilian situations as well, such as during the aftermath of the Swissair Flight 111 crash at Peggy’s Cove in Nova Scotia on 2 September 1998. Over 7000 people, ranging from pathologists who examined body fragments to children who saw the tragedy unfold, received a form of CIS counselling from military and civilian CISD teams. See *The Globe and Mail*, 21 October 1998.

¹⁶⁸ Birenbaum, “Peacekeeping Stress Prompts New Approaches,” 1484.

¹⁶⁹ Department of National Defence, *Preparing for Critical Incident Stress*, 10.

¹⁷⁰ Spellman interview.

¹⁷¹ Andrew Godin, e-mail message to author, May 27, 2015.

boys get him drunk and encourage him to let it out.”¹⁷² While aware of the existence of CIS teams, Davis maintained that no team visited during his 1992 Croatia tour, and even if they had, “Every soldier knows not to talk to these clowns.”¹⁷³ He cited an instance when a friend admitted being troubled by his operational experiences, only later to be identified as “an emotionally unstable character.”¹⁷⁴ Regardless of its authenticity, such stories ensured that soldiers kept a tight lid on their experiences and sought comrades’ ears rather than risk divulging too much to a “suit.”

CISD proved incapable of preventing long-term mental health problems for many Canadian peacekeepers returning from the former Yugoslavia during the 1990s. The reasons included: a culture of toughness and masculine prowess that inhibited soldiers from speaking out about their psychological difficulties — a type of collective and self-stigmatization which produced outright denial; fears of how reporting a mental illness might affect their military career; a conscious attempt by an “old guard” among CAF leadership to deny PTSD’s existence; and a socio-political milieu that left many soldiers feeling abandoned by both their unit and their country. Living within a culture of denial and suppression, and unable to attach their peacekeeping experiences to any tangible or nationally-supported cause, psychologically injured soldiers suffered in silence. It required several key events across the 1990s, and a board of inquiry into the seemingly high rate of illness among Balkans peacekeepers, to begin a large-scale shift in consciousness about the links between peacekeeping and mental trauma.

¹⁷² James Davis, *The Sharp End*, 112.

¹⁷³ Ibid.

¹⁷⁴ Ibid.

CHAPTER 5: BREAKING DOWN THE WALL

I mean my personal sense is that ... psychological trauma in these kinds of situations is one of the toxic exposures that occurs. And it is as valid, if not more valid, than many of the other types of toxic exposures that veterans concern themselves with. But that is -- it is more than just an awareness issue. PTSD has baggage with the veterans community.¹

People were afraid to talk about it [PTSD, stress symptoms], you know. Fear of looking weak or whatever ... Fear of being released from the Forces because, you know, you are either ... a weak sister or you have got something wrong with you so we will kick you out ... You would hear here and there about things like, you know, guys wondering if they are ever going to have a solid stool again or if they are ever going to sleep the night again without waking up ... or flying into a towering rage at their wife or their family about nothing at all. Guys don't really want to talk about that ... unless they are with their really trusted confidantes. I think a lot of guys kept things inside and guys wouldn't say much ... The system does not reward weakness ... It punishes weakness and ... throws it away.²

When Corporal Prodaniuk returned from UNPROFOR peacekeeping duties in April 1995 he encountered a “wall of silence” surrounding discussions about what Canadian peacekeepers witnessed or actions they took against hostile forces.³ He noticed that military leaders only wanted troops to cite the positive side of peacekeeping:

They wanted us to sort of address what was making the nightly news – show Canadian peacekeepers saving kids, handing out humanitarian aid, something ... But they didn't really want to know about us being in actions where we were taking positions or moving belligerents off a hill ... sometimes engaging a belligerent force to get them to move, or to do something we wanted them to do. That wasn't something they wanted discussed. And so the command didn't really want to bring it up ... So there was this kind of weird repression of what we did and experiences we were involved in ... And so when you came home, it was just sort of a 'shut up' culture ... So what ended up happening was, you came back and you just moved on with life. You didn't really talk about things.”⁴

Prodaniuk initially felt no signs of psychological difficulties, so he channeled his energy into becoming an even better soldier, following the culture that encouraged him to “soldier on.”

¹Testimony of Lieutenant-Colonel Charles Engel, *Croatia Board of Inquiry*, November 23, 1999, vol. XXVII, 37.

² Testimony of MWO Patrick Lawler, *Croatia Board of Inquiry*, October 18, 1999, vol. XIX, 12.

³ Susan Brock and Greg Passey, “The Canadian Military and Veteran Experience,” in Raymond Scurfield and Katherine Platoni, eds., *War Trauma and Its Wake: Expanding the Circle of Healing* (New York: Routledge, 2013), 91.

⁴ Prodaniuk interview.

Several years went by as he gradually became more “emotionally unstable.”⁵ He had difficulty sleeping and was troubled by memories of harrowing incidents that continued to repeatedly play in his mind.⁶ Prodaniuk felt that since he had not been in a traditional combat zone, he “shouldn’t have any reason to have a [psychological] problem.”⁷ Like numerous comrades during the 1990s, Prodaniuk’s knowledge of psychological trauma was “razor thin” and consisted of what he saw in Vietnam War films.⁸ Thus, he did not make a link between war trauma and his own difficulties.⁹ Feeling disaffected, he decided to make a change, and became a Materials Technician with the Electrical and Mechanical Engineers corps in 1999. Shortly thereafter, he crashed. He recalled: “I went to a different part of the Army, then, all of a sudden everything sort of unpacked. It was almost as if the social conditions of the battalion were sort of keeping me wired, or keeping me compressed in a way. And once I left, that social support sort of dissolved, and everything became unpacked.”¹⁰ Prodaniuk became depressed and sometimes resorted to alcohol to cope. He found himself “losing perspective all the time,” and just as his psychological difficulties became almost too much, he decided to finally get help.¹¹ He went for numerous rounds of counseling, and in 2000-2001 was medically released with PTSD. Reflecting on his journey, Prodaniuk affirmed that the key factor in his gradual deterioration was the “failed processing” of what he experienced in theatre. He declared that above all else, “that in the end is what did me in.”¹²

Prodaniuk’s poignant recollections and eventual realization about the effects peacekeeping incidents had on his mind are crucial because they highlight several of the key

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

factors which shaped conceptualizations of trauma in the CAF during the 1990s. The wall of silence Prodaniuk encountered in his battalion was a microcosm of a much larger wall raised by DND and CAF leaders to prevent scandal and downplay peacekeeping's effects on Canadian soldiers. That silence had profound consequences for numerous soldiers as they returned to a military that seemed indifferent about their accomplishments and a country that seemed to care little for the sacrifices they made. For those whose experiences proved debilitating, military leaders' refusal to acknowledge peacekeeping trauma also ensured that numerous soldiers were released from the Forces and denied a pension.

At a social level this chapter examines the loss and abandonment many peacekeepers felt when they returned home, and how those feelings affected their psychological state in a manner that was all too real despite being difficult to quantifiably measure. Moreover, Prodaniuk's trouble coming to terms with what ailed him was reflective of a masculine fitness culture that discouraged succumbing to injuries and was especially critical of psychological difficulties. Military culture produced a self- and group-disciplining among its members, causing injured soldiers to deny any problem for fear of being ostracized by comrades or released from the Forces. The situation finally came to a head in July 1999 when the Croatia Board of Inquiry (BOI) was called to determine the cause of a high number of casualties stemming from the UNPROFOR mission. The BOI spotlighted the existence of altered though still present ideas of mental disorder that in fact resembled discussions from the First and Second World Wars.

Under Somalia's Shadow

CAF and DND leaders had little desire to discuss the possibility of peacekeeping trauma during the 1990s. As discussed in the previous chapter, the shadow of Somalia, and the sense of

distrust it created between the CAF/DND and the Canadian public, loomed large over any military-related issues for most of the decade: “If Canadians were thinking of the military at all,” their attention was largely focused on the Somalia Affair and its aftermath.¹³ In his retrospective assessment of the 1990s, Brigadier-General (ret.) G.E. “Joe” Sharpe wrote that “senior Department of National Defence officials were not in the mood to disclose anything about operations that was not absolutely necessary.”¹⁴ Their reticence extended not just to operation specifics (e.g. Canadians fighting at Medak), but also to any after-effects, including peacekeepers’ mental difficulties. Thus, for much of the 1990s the problems soldiers and veterans faced were known to few Canadians outside of the military, and even some within it.

Nevertheless, there were several events throughout the decade that slowly put pressure on the CAF and DND to acknowledge an evidently growing problem. In addition to Passey’s peacekeeping trauma research, other signs of trouble arose in March 1995 when a distraught mother confronted MND David Collenette outside the House of Commons. The woman’s son, a member of the Royal 22nd Regiment (the “Van Doos”) committed suicide a year earlier.¹⁵ Although his death was not linked to service in the former Yugoslavia, she confronted Collenette on a day when he was responding to allegations that a “rash” of suicides among Quebec-based soldiers was connected to peacekeeping trauma.¹⁶ While CFB Valcartier spokesperson Jocelyn Laroche admitted the base had seen nine suicides in the previous two years – the timeline coinciding with the beginning of the UNPROFOR mission – he affirmed that only three

¹³ G.E. Sharpe, *Croatia Board of Inquiry: Leadership (and Other) Lessons Learned* (Winnipeg: Canadian Forces Leadership Institute, 2002), 3.

¹⁴ *Ibid.*, 4.

¹⁵ The “Van Doos” are so designated because of the French pronunciation of the Regiment’s name.

¹⁶ *The Toronto Star*, 31 March 1995; For another article that examined the issue of suicides in the Van Doos see *The Globe and Mail*, 8 April 1995.

instances involved soldiers who served in the former Yugoslavia.¹⁷ Nevertheless, in the same *Toronto Star* article the base hospital's chief psychiatrist, Lieutenant-Colonel Louis Berard, said he had seen over thirty cases of PTSD directly linked to UNPROFOR service, hinting at a much larger problem. Berard, like Lieutenant-Commander Passey, acknowledged that Canadian peacekeepers had been "exposed to extremely traumatic experiences overseas."¹⁸ The article highlighted what became an all-too-familiar refrain later in the decade: peacekeeping veterans were "afraid to seek counselling for fear of hurting their military careers."¹⁹

A second, more publicized event throughout the second half of the 1990s was Lieutenant-General Roméo Dallaire's personal struggles with PTSD following his ill-fated tenure as Force Commander of the United Nations Assistance Mission for Rwanda (UNAMIR) in 1993-1994. Although most Canadians later became acquainted with Dallaire's story because of his bestselling 2003 book *Shake Hands with the Devil*, like numerous soldiers, his battle with PTSD developed much earlier, and over a number of years.²⁰ Dallaire acknowledged the great emotional toll UNAMIR service had on its participants, and took the unprecedented step of requesting mental health assistance for himself, his UN Military Observer officers, and their spouses or partners.²¹ In July 1995, Lieutenant-Commander Passey, Major Lamontigny (a social worker), and a mental health team spent two days at CFB St. Jean conducting CISD and

¹⁷ Ibid.; A 1996 independent study by a team at Toronto's Clarke Institute of Psychiatry into suicides in the military found "few direct links" between peacekeeping duties and any of the sixty-six suicides in the CAF from 1990 to 1995. Nevertheless the study highlighted the "macho military culture" that prevented many from coming forward. The CAF responded by implementing (at least in theory) a plan whereby peacekeepers were given at least a year at home between deployments. See *The Globe and Mail*, 8 November 1996.

¹⁸ *Toronto Star*, 31 March 1995

¹⁹ Ibid.

²⁰ Roméo Dallaire, *Shake Hands with the Devil: The Failure of Humanity in Rwanda* (Toronto: Vintage Canada, 2004 [2003]).

²¹ Ibid., xii.

educating officers and their families about stress disorders.²² Those sessions represented an historic first, as they were the first CAF initiatives specifically designed to address PTSD and its effects on soldiers and their families.²³

Dallaire's experience with PTSD mirrored many subordinates' struggles during the 1990s.²⁴ Although he took steps to raise awareness of operational stress, and spoke publicly after his return from Rwanda about his struggle, nonetheless, "Camouflage was the order of the day."²⁵ In a manner akin to Barry Westholm, Greg Prodaniuk, and Andrew Godin, Dallaire soldiered on and became a workaholic. He accepted all tasks sent his way and kept busy to avoid troubling memories.²⁶ Unfortunately, also like Westholm et al., Dallaire's attempts to suppress his inner demons were in vain. Four years after returning from Rwanda, in September 1998, his mind "decided to give up" and he was ordered by CDS Maurice Baril to take a month's sick leave.²⁷ In an internal e-mail quoted by the *Globe and Mail*, Dallaire cited his "operational experiences" and their effect on his health as the reason for his imposed leave.²⁸

Throughout his struggle with PTSD in the 1990s, Dallaire worked with others of a like mind to raise awareness of what troubled numerous peacekeepers. One such ally was Captain Stéphane Grenier, a military officer who served in Rwanda in 1994-1995 as UNAMIR Spokesperson. Like numerous peacekeepers, Grenier returned to Canada "very messed up."²⁹ In

²²Brock and Passey, "The Canadian Military and Veteran Experience," 92; Passey and Lamontigny were deployed to Rwanda in 1994, along with a mental health team, to appraise the mental health impact of UNAMIR service on Canadian participants.

²³ Ibid.

²⁴ Although it cannot be doubted that Dallaire's rank helped him avoid many of the problems his subordinates faced, what this dissertation suggests is that his slow, gradual decline and mental processing of his situation, as well as his attempts to stave off the inevitable crash, were similar in kind to those lower in rank.

²⁵ Dallaire, *Shake Hands with the Devil*, xi.

²⁶ Ibid., xii.

²⁷ Ibid; Dallaire's "final straw" came when he testified before the International Criminal Tribunal for Rwanda in 1998: "The memories, the smells and the sense of evil returned with a vengeance." See *ibid*.

²⁸ Ibid.

²⁹ Grenier, Stéphane. Interview by author. Telephone. Toronto, September 25, 2014; Grenier was later diagnosed with PTSD.

an e-mail to Grenier in 1997, Dallaire espoused the need to produce a video about events in Rwanda and how they affected Canadian UNAMIR participants.³⁰ Unable to obtain government funding unless the video had a tangible purpose, Grenier devised the idea of focusing on the “human cost” of peacekeeping missions, thus making it useful as a training video.³¹ Dallaire liked the idea and gave him the go ahead to produce it. Over the next several months Grenier put together something unlike past CAF videos, utilizing candid interviews with UNAMIR peacekeepers affected by their Rwanda deployment. When it came time for Dallaire to be interviewed, he was unsure of what to say about his experiences, and consulted Grenier about different options. Together, they decided it was necessary for both Dallaire and his subordinates to “lay it all down.”³²

In the final 1998 video, titled *Witness the Evil*, Dallaire and other Canadian peacekeepers provided an uncensored report of what they experienced in Rwanda. Dallaire described his thoughts of suicide after Rwanda and encouraged other sufferers to come forward. Nonetheless he also candidly highlighted the barriers for those with mental illness: “Sometimes I wish I had lost a leg, instead of having all those brain cells screwed up. You lose a leg, it’s obvious, you’ve got therapy; you’ve got all kinds of stuff. You lose your marbles ... very, very difficult to explain; very difficult to gain that support that you need. But those who don’t recognize it and go get the help [they need], are going to be a risk to themselves and to us.”³³ The image of a high-ranking CAF officer in his UN uniform almost breaking down on camera was unprecedented. The video struck a chord with the public, and excerpts were aired by the CBC on both radio and

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ Canada, Department of National Defence. *Witness the Evil – A Canadian Forces Video*, 1998.

The National television program in November 1998.³⁴ Given the wide reach of CBC programming, *Witness the Evil* did much to bring Canadians' attention to peacekeeping trauma and forced the military "to actually pay more attention."³⁵

Although Dallaire's rank allowed him the privilege of being spared an ignominious release from the CAF – a fate which befell many rank-and-file soldiers throughout the 1990s – even he encountered resistance to his open advocacy for soldiers suffering from PTSD and other stress-related illnesses. Brigadier-General (then Colonel) Sharpe, future Chair of the Croatia Board of Inquiry, recalled that during the 1990s "many senior CAF officers ... felt Roméo was out of line when he started this approach."³⁶ Sharpe's appraisal was bolstered by a high-ranking officer diagnosed with PTSD, who reported that, "When Roméo Dallaire came forward, some senior officer said of him that he's 'always been emotional,' and to them 'emotional' is considered a weakness."³⁷ Dallaire's openness about mental disorders ran up against a "strong lobby from an old guard" who, like numerous military leaders across the century, dismissed stress disorders as a sign of weakness and personal failings.³⁸ The conflict between traditional and novel approaches to mental trauma in the CAF represented an "ongoing major difference of opinion" between men like Dallaire, and others like Major-General Lewis MacKenzie, from the "suck it up buttercup" school of thought, who believed that publicizing the PTSD issue actually

³⁴"Canada's Veterans: Veterans and Post-Traumatic Stress." *The National*. Canadian Broadcasting Corporation Digital Archives, Toronto: CBC, November 25, 1998, <http://www.cbc.ca/player/Digital+Archives/War+and+Conflict/Veterans/ID/1842315607/> (accessed August 1, 2014); "Witness the Evil." *As It Happens*. Canadian Broadcasting Corporation Digital Archives, Toronto: CBC, November 26, 1998, <http://www.cbc.ca/archives/entry/blue-berets-shell-shock> (accessed August 1, 2014).

³⁵ Grenier interview.

³⁶ G.E. Sharpe, e-mail message to author, October 14, 2014.

³⁷ Quoted in André Marin, Ombudsman, National Defence and Canadian Forces, *Report to the Minister of National Defence, Special Report: Systemic Treatment of CF Members with PTSD, Complainant: Christian McEachern*. (Ottawa: Department of National Defence, 2002), 65.

³⁸ Off, *The Ghosts of Medak Pocket*, 245.

created more mental health casualties.³⁹ For much of the 1990s the latter group held the upper hand.

A third crack in the wall of silence came in October 1998 when the House of Commons Standing Committee on National Defence and Veterans' Affairs (SCONDVA) produced a Parliamentary Report, titled *Moving Forward: A Strategic Plan for Quality of Life Improvements in the Canadian Forces*.⁴⁰ The main catalyst for the Committee's investigation was a consistent stream of news reports, many similar to the 1995 article, which expressed injured military personnel and their families' anger at the DND's "apparent indifference to their situation."⁴¹ As one example of that indifference the Report cited instances when medals earned by those killed in action were simply mailed to family members and spouses.⁴² The Report was based on a year of hearings focused on major issues affecting the daily lives of men and women in the CAF. Its conclusions were less than flattering for military leaders. Among other things, the Report provided an unveiled critique of the CAF's handling of psychological casualties, admonishing military leaders that psychologically injured soldiers required "as much care and especially

³⁹ Sharpe, e-mail message, October, 14, 2014; One cannot help but notice the similarity of the latter's view to that expressed by historic military figures such as American General George Patton. It also resembles the "contagion" theory espoused by some military leaders in the First World War.

⁴⁰ Parliament of Canada, *Moving Forward: A Strategic Plan for Quality of Life Improvements in the Canadian Forces*. Report of the Standing Committee on National Defence and Veterans' Affairs, October 1998. <http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=1031525&Language=E&Mode=1&Parl=36&Ses=1&File=6> (accessed August 4, 2014); The CAF had undertaken its own internal investigation in response to bad press in 1997 under chief social worker Lieutenant-Colonel Rick McLellan. His report, *The Care of Injured Personnel and their Families Review*, was aimed at determining the extent to which the CAF/DND were succeeding or failing in their care of injured personnel and families. Made public in 1998, the Review concluded, inter alia, that the problems experienced by those physically or psychologically wounded as a result of service were symptomatic of a larger, systemic problem with how the CAF and VAC handled injured personnel. The strongly worded tone of the *Review* reflected McLellan's anger at what was evidently an antiquated system and one which left many Regular Force soldiers and Reservists without proper care. See Canada, Department of National Defence, *Injured Personnel and Family Review Team*, R.G. McLellan, *Care of Injured Personnel and their Families Review: A Final Report* (Ottawa: Department of National Defence, 1997); For an example of McLellan's public outspokenness about the issue see *The Globe and Mail*, 1 May 1998; An even less publicized report was also prepared earlier in 1997 that focused on CAF members released on medical grounds. See Canada, Department of National Defence, J.W. Stow, *A Study of the Treatment of Members Released on Medical Grounds* (Ottawa: Department of National Defence, 1997).

⁴¹ House of Commons, *Moving Forward*.

⁴² Ibid.

understanding as those injured physically.”⁴³ The Committee also contacted serving and former members of the CAF injured during service. Firsthand accounts from former peacekeepers confirmed what many injured CAF members felt – namely that the Forces and DND had “lost touch with the realities faced by injured personnel.”⁴⁴

Another important step towards reform came with the June 1998 creation of a CAF/DND Ombudsman. In the wake of the Somalia Affair and sexual harassment scandals, calls for greater transparency and accountability placed pressure on the DND and MND Art Eggleton to take tangible steps toward breaking down the insularity plaguing both organizations.⁴⁵ The first Ombudsman, André Marin, was a former Crown attorney and Director of Ontario’s Special Investigations Unit. Marin’s “insistence on openness” and “penchant for news conferences” during his SIU tenure drew displeasure from police leaders and demonstrated he was unafraid of eschewing political niceties to achieve results.⁴⁶ Commenting on Marin’s appointment, military historian Jack Granatstein told the *Globe and Mail* that Marin’s openness and insistence on accountability was “just what the Canadian military needs right now.”⁴⁷ Despite Marin’s appointment though, more than a few eyebrows were raised when Eggleton announced Marin (and future Ombudsmen) would report directly to the MND, leaving many wondering whether the position *really* had the means to conduct “independent” investigations.⁴⁸

⁴³ Ibid.

⁴⁴ Ibid; The SCNDVA’s report proved to be a “turning point” in overall Canadian military quality of life, as its broad scope and recommendations set forth a number of tangible goals that were required to improve an evidently moribund system. For more on quality of life initiatives and their connection to civilian practices see Deborah Cowen, *Military Workfare: The Soldier and Social Citizenship in Canada* (Toronto: University of Toronto Press, 2008), passim, esp. 220-222.

⁴⁵ Scott Taylor and Brian Nolan, *Tested Mettle: Canada’s Peacekeepers at War* (Ottawa: Esprit de Corps Books, 1998), 247.

⁴⁶ *The Globe and Mail*, 8 June 1998.

⁴⁷ Ibid.

⁴⁸ Taylor and Nolan, 246-247; *The Globe and Mail*, 10 June 1998; That system meant the Ombudsman was outside the CAF chain of command but not necessarily free from DND machinations and/or politics.

Nevertheless, Marin quickly moved forward, and true to his pugnacious reputation became a “burr under their [CAF/DND leaders’] saddle” from 1998 to 2005.⁴⁹ According to *Ottawa Citizen* reporter David Pugliese, who covered numerous CAF/DND topics throughout the 1990s, although the Ombudsman position was created as somewhat of an “escape valve” to deflect criticism, “they [the CAF/DND] got more than they bargained for, because he [Marin] wasn’t worried about what the Generals thought. He conducted a pretty high profile campaign. I don’t think they expected that.”⁵⁰ Throughout the length of his seven-year tenure, Marin publicized and investigated numerous systemic issues within the CAF, on several occasions drawing attention to the treatment of soldiers with PTSD.⁵¹ He also, as during his Ontario SIU Directorship, became a polarizing figure. A federal report commissioned by his successor Yves Côté declared that Marin’s staff expressed “overwhelming relief” at his departure.⁵² The report moreover stated that 150 staff left during Marin’s tenure, an ostensibly higher than normal turnover rate.⁵³ Marin’s spokesperson countered that he handled 2000 cases a year, published twenty-six special reports, and was a transformative figure who initiated positive changes for soldiers and their families.⁵⁴ A 2005 *Toronto Star* article about Marin’s departure agreed, stating that his office was “a welcome arbitrator able to break through the red tape and bureaucratic intransigence that could make life hell” for soldiers.⁵⁵

Beginning in 1992, American – and later British and Canadian – Gulf War veterans began to present a wide array of symptoms ranging from fatigue to cancer.⁵⁶ The symptoms’ inexplicable nature led to investigations into physical exposures to toxins, particularly focused

⁴⁹ *The Toronto Star*, 29 March 2005.

⁵⁰ Pugliese, David. Interview by author. Telephone. Toronto, November 10, 2014.

⁵¹ Discussed in the subsequent chapter.

⁵² *The Toronto Star*, 2 June 2010.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ *The Toronto Star*, 29 March 2005.

⁵⁶ Jones and Wessely, *Shell Shock to PTSD*, 167.

on insect repellents and nerve-gas antidotes administered to Gulf War participants.⁵⁷ Despite the fact that none of the approximately 5000 Canadians who served in the Gulf War reported serious illnesses from toxins during the conflict, numerous men and women subsequently complained of fatigue, depression, digestive problems, and a myriad of other symptoms.⁵⁸ Pressure was put on all three governments to act after media reports gave the impression that the problem was transnational and therefore had its roots in the Persian Gulf. Nevertheless, although the commonality of certain symptoms led some to refer to the manifestations as “Gulf War Syndrome (GWS),” no single problem was identified as the culprit.⁵⁹ GWS, like shell shock and battle exhaustion before it, symbolized and captured the stresses of “a unique war with unique stresses.”⁶⁰ It was, a military study affirmed, the psychological stress of being under constant threat of biological or chemical weapons that produced GWS, rather than the weapons themselves.⁶¹ Colonel Cameron Scott, who reported on the CAF’s findings after sending out 6000 questionnaires to Gulf War veterans, concluded that “the strongest association to adverse health outcomes was [related to] psychological stressors.”⁶²

⁵⁷ *The Globe and Mail*, 17 May 1996; Jones and Wessely linked the fear of physical toxins to “powerful cultural themes” in the civilian context brought into a military one. The general fear of radiation, pesticides, etc., that began in the post-1945 era became even more heightened in the 1980s and beyond after events such as the Bhopal disaster, Chernobyl, and other mass exposures to human-made weapons and chemicals made death by those materials seem all the more possible. The Vietnam War and Agent Orange also played a key role in raising fears among soldiers of chemicals. See Jones and Wessely, *Shell Shock to PTSD*, 198-199.

⁵⁸ *The Toronto Star*, 30 June 1998.

⁵⁹ Jones and Wessely, *Shell Shock to PTSD*, 167.

⁶⁰ *Toronto Star*, 30 June 1998.

⁶¹ Canada’s lone clinic for assessing those suffering with GWS from 1992 to 1998 was the Chronic Fatigue Syndrome Clinic, later renamed the Gulf War Veterans Clinic. It was established and run by Colonel Ken Scott. For more information on Canadian research and treatment of GWS see the Testimony of Major Timothy Cook, *Croatia Board of Inquiry*, November 19, 1999, vol. XXVI, passim.

⁶² *Ibid*; This number included those who stayed in theatre after the initial conflict was over. Thus, the discrepancy in the numbers - 4500 initial participants plus those who served after in Kuwait or elsewhere; A 2005 Statistics Canada report on Persian Gulf veterans’ health concluded that “Canadian Gulf War veterans (both retired and currently serving) did report symptoms and common illnesses at significantly higher rates than other veterans of the same era” but were not at increased risk of developing cancer or dying, further pointing to the possibility of psychological causes. See Statistics Canada, *The Canadian Persian Gulf Cohort Study: Detailed Report* (Ottawa: Statistics Canada, 2005), 47.

In June 1998, when Dallaire, then Assistant Deputy Minister (Personnel), agreed with the questionnaire's conclusions and demanded that GWS sufferers be treated in the same manner as physical casualties, it was evident that a small but noticeable shift was occurring within the halls of National Defence Headquarters.⁶³ The belief that psychological stresses alone could be responsible for causing debilitating symptoms in Gulf War veterans would have been unthinkable at the beginning of the decade, but it was abundantly clear to a small cadre of military leaders by the late 1990s that traditional ideas of combat stress must be cast off. Several factors combined to break through traditionalists' attempts to ignore, downplay, or deny the existence of numerous psychological casualties: New research into peacekeeping trauma; consistent media reports of soldiers' problems after service; public inquiries into those problems; Dallaire's public battle with PTSD and subsequent advocacy; and the GWS controversy.⁶⁴ In July 1999, a military board of inquiry was called which became the culmination of all the previous struggles over the past decade. The Croatia Board of Inquiry (BOI) finally exposed the extent – both numerically and qualitatively – of problems Canadian peacekeepers faced during and after service. The BOI became a flashpoint that changed the way many military leaders viewed psychological trauma, and highlighted the human cost of peacekeeping for all Canadians to see. It also provided historians with a unique look behind the wall of silence that existed throughout the 1990s. Looking beyond that wall highlights the continuation of altered, though still present ideas of proper manliness and soldierly behaviour, the connection made between psychological trauma and personal weakness, and the very real effect that a perceived lack of social support – à la Vietnam – had on Canadian peacekeepers.

⁶³ Ibid.

⁶⁴ This of course is not an exhaustive list, but some of the key events/factors.

The Croatia Board of Inquiry

Two key events occurred in 1998-1999 and precipitated the military calling the BOI. The first was the case of retired Warrant Officer Matt Stopford, a Medak veteran discharged in October 1998 after becoming partially blind and suffering from a myriad of symptoms ranging from aching joints to intestinal bleeding.⁶⁵ Stopford's case made national news after he, along with two other injured peacekeepers, personally confronted MND Art Eggleton outside the House of Commons about problems soldiers faced obtaining a pension for injuries.⁶⁶ Stopford's case was particularly mystifying and created a storm of controversy after a book published in 1998 by journalists Scott Taylor and Brian Nolan noted that Canadian peacekeepers at Medak had been forced to use soil "tailings" found around an abandoned mineshaft to make protective sandbags.⁶⁷ When it was alleged the soil contained trace amounts of bauxite and uranium, Taylor and Nolan as well as Canadian newspapers implied a link between Stopford's illness and the "red dirt."⁶⁸ Connected to this story were reports that Lieutenant (Navy) Eric Smith, a physician who served on a 1994 tour in the Medak region and noticed the red soil, wrote a memo in January 1995 warning of possible toxic exposure and had a copy placed in the file of every

⁶⁵ Sharpe, *Croatia Board of Inquiry*, 8; Stopford became a "poster boy" for soldiers suffering ill effects from deployment. Sharpe and board member Mike Spellman later convinced Stopford to testify at the BOI, because Sharpe was convinced if "we could get him to come and talk to the board then we would be able to get most of the soldiers to open up." G.E. Sharpe, e-mail message to author, October 8, 2014.

⁶⁶ *The Globe and Mail*, 5 November 1998; One of Stopford's comrades, Tom Martineau, who was paralyzed from the waist down after being hit by a sniper bullet in Bosnia in 1994, had his wheelchair taken away from Veterans Affairs due to bureaucratic considerations. On another occasion doctors would not authorize his release because his parents' house did not have a wheelchair ramp, something which VAC initially refused to pay for. See *ibid.* Even after Stopford's case made national news his disability was still initially placed at only 25%, entitling him to only \$432 a month. See *The Globe and Mail*, 17 August 1999.

⁶⁷ Taylor and Nolan, *Tested Mettle*, 233-234.

⁶⁸ *Ibid.*; Also referred to as the "red soil." See also *The Globe and Mail*, 5 November 1998 for an example of how Taylor and Nolan's book was utilized to make a link between contaminants in Croatia and Stopford's (and other soldiers') health issues.

soldier who served in Croatia and Bosnia from 1992-1993.⁶⁹ The media revealed that Smith's letter was surreptitiously removed from most soldiers' files, and accusations of a cover-up quickly became national news.⁷⁰ The media scrum surrounding the Stopford case, soldiers' ostensible exposure to harmful substances, and an inexplicably high number of peacekeeping casualties proved to be the straws that broke the camel's back, and in July 1999 MND Art Eggleton ordered a board of inquiry into the matter.⁷¹ Retrospectively, the "red dirt" scare demonstrated the extent to which the media, rank-and-file soldiers, and military leaders still looked to *physical* causes to explain mysterious peacekeeping injuries, despite the piecemeal but nevertheless growing evidence that the cause of many injuries was a more insidious one.

Thus, amidst numerous scandals across the decade and under public scrutiny, the BOI was called to investigate the high number of peacekeeping injuries stemming from UNPROFOR service.⁷² The Board's initial (and official) mandate was to examine whether from 1993 to 1995 CAF members in the area of Croatia designated Sector South were subjected to "environmental contaminants" in quantities strong enough to pose a health hazard.⁷³ The Board's very narrow

⁶⁹ Off, *The Ghosts of Medak Pocket*, 245; Stopford learned about the memo because someone slipped a copy under his door. See *The Globe and Mail*, 23 July 1999; Ostensibly because of his actions Smith was later court-martialed and medically released. See Testimony of WO Matthew Stopford, *Croatia Board of Inquiry*, October 28, 1999, vol. XXIII, 9.

⁷⁰ *The Globe and Mail*, 22 July 1999; 23 July 1999; 28 July 1999; 29 July 1999; Media reports made it clear that numerous soldiers had drawn a link between their exposure to toxins and their subsequent illnesses as early as April 1997, but an internal investigation into the matter "stalled" in May 1998. The 28 July *Globe* article also contained a picture of a 1994 report Smith wrote to the DND which mentioned a destroyed bauxite plant. See *ibid*.

⁷¹ Before the Board even began in earnest, the *Globe and Mail* revealed the extent of suspicion that had grown throughout the decade when it stated that among other breaches of faith "it is clear the military dragged its feet when looking into soldiers' health complaints." See *The Globe and Mail*, 31 July 1999.

⁷² Under the National Defence Act, the MND, CDS, or "such other authorities as the Minister" has the authority to call a board of inquiry into "any matter connected with the government, discipline, administration or functions of the Canadian Forces or affecting any officer or non-commissioned member." A board of inquiry has significant legal power in that it can call military and civilian persons to give oral or written evidence (on oath) about the matter at hand. A board also has the authority to compel a person to give evidence under oath *even if* that evidence will incriminate them (self-incrimination is usually protected by the Canadian Charter of Rights and Freedoms). See *National Defence Act, Revised Statutes of Canada 1985*, c. N-5 <http://laws-lois.justice.gc.ca/eng/acts/n-5/page-18.html#h-32>

⁷³ Sharpe, *Croatia Board of Inquiry*, 1; The Board consisted of: Chairman (and Air Force officer) Colonel Joe Sharpe; RCMP Inspector Reg Bonvie; Major J.P. Caron from the Van Doos, also a Croatia veteran; Lieutenant-

mandate mirrored the desire of most soldiers – and their chain of command – to find a tangible, physical cause for troops’ inexplicable health problems. By not responding to early concerns about the “red dirt” and removing Smith’s letter, the military inadvertently encouraged the belief that soldiers’ problems were of a physical nature.⁷⁴ Throughout the Board’s existence, its members met and spoke with approximately 2000 soldiers and their families.⁷⁵ From the beginning, Chairman Sharpe was convinced the only way to gain soldiers’ trust was to demonstrate the Board had front-line veterans’ confidence. To achieve that trust Mike Spellen, a retired Master Warrant Officer and Croatia (Medak) veteran was asked to participate as a Board member. Sharpe kept Spellen close at hand throughout the process, especially when speaking at press conferences or with the rank and file.⁷⁶

It was the plethora of face-to-face discussions and initial days of testimony that convinced Sharpe and the other Board members that “there was a much larger issue” than potential contaminant exposure.⁷⁷ When asked to recall the Inquiry’s initial stages, Spellen focused on how surprised he was to see former comrades arriving to testify with their wives, and in a few cases, their mothers.⁷⁸ After testimonies began, it was clear why. Spellen stated: “I had

Colonel Brian Sutherland, Reserve Adviser to the Chief of the Land Staff; Master Warrant Officer (ret.) Mike Spellen, a Croatia veteran; Major Dave Widdows from the Director General Environment’s office; Marc Pilon, CAF Ombudsman’s representative; Dr. Jeff Whitehead, Medical Adviser to the Board; Public Affairs Officer Lieutenant-Colonel Jacques Tremblay; and Legal Adviser, Commander Jane Harrigan.

⁷⁴ Sharpe, *Croatia Board of Inquiry*, 25.

⁷⁵ Ibid., 10.

⁷⁶ Spellen accompanied Sharpe when the latter was called to meet with anyone in the chain of command, from the CDS and MND down to the rank-and-file soldiers. This approach led to some “bruised egos” since “Mike [Spellen] was never a diplomat,” but in Sharpe’s mind it ensured that the best evidence came out. Sharpe glowingly described Spellen as “honest as the day is long.” Sharpe, e-mail message to author, October 17, 2014; Sharpe’s decision proved prescient when one soldier testifying at the Board stated: “[T]he only reason I am here is because Mr Spellen called and asked me because I didn’t believe in what was happening. And the only reason why I am here is because of that man there [Spellen].” Testimony of Sergeant Christopher Byrne, *Croatia Board of Inquiry*. November 25, 1999, vol. XXIX, 8; Another tactic taken by Sharpe was to dress in civilian clothes when meeting with the media and rank-and-file soldiers. While perceived as a sign of disloyalty by some “senior members” of the military, it helped to further gain the trust of soldiers, who were more likely to see board members as working on their behalf, instead of representing the establishment. See Sharpe, *Croatia Board of Inquiry*, 54-58.

⁷⁷ Sharpe, *Croatia Board of Inquiry*, 10.

⁷⁸ Spellen interview.

no idea some of these guys were horrifically sick ... and they're showing up with their wives or their mother in a couple of cases, due to the fact that they were so emotionally unstable ... Best of my recollection, there wasn't one testimony from troops where they didn't break down. Everyone broke down, and that's from colonel down."⁷⁹ Sharpe noticed a distinct pattern emerging in discussions both on and off the record. Soldiers reported digestive problems, wild mood swings, and great difficulty sleeping, as well as nightmares.⁸⁰

Hence, the Board sensed early on it was only viewing 10% of the iceberg, and decided, with permission from Convening Authority Lieutenant-General Mike Caines, to expand its mandate to include "the much broader issue of how the Canadian Forces and Canada care for military personnel who are injured in the course of their duties."⁸¹ The Board was also influenced by military historian Allan English's work on combat stress among Canadian aircrew during the Second World War.⁸² Board member Lieutenant-Colonel Brian Sutherland previously took a Royal Military College course offered by English in 1997. At various points in the course English discussed his PhD thesis work on "flying stress."⁸³ Thus when the Board sensed that stress might be a factor in peacekeepers' health problems, Sutherland mentioned English's work to Chairman Sharpe. The latter, who knew English from previous work conducted for the Air Force, telephoned English to discuss the matter.⁸⁴ From that conversation Sharpe decided the Board could use English's help, and commissioned him in the fall of 1999 to produce a meta-

⁷⁹ Ibid; Joe Sharpe remembered one particularly emotional testimony during which he turned to the back of the room and saw even the Board's two translators distraught and in tears. Sharpe, e-mail message to author, November 4, 2014.

⁸⁰ Sharpe, *Croatia Board of Inquiry*, 27.

⁸¹ Ibid., 10; The Board was able to use an obscure paragraph in its "terms of reference," which allowed it the freedom of movement to shift its attention toward anything that might be deemed relevant. See Allan English, "From Combat Stress to Operational Stress," 14.

⁸² Sharpe, *Croatia Board of Inquiry*, 37.

⁸³ Allan English, e-mail message to author, July 3, 2015.

⁸⁴ Ibid.

analysis paper on the historical dimensions and interpretations of combat stress and PTSD.⁸⁵ English submitted his paper in October 1999, and it constituted one of several factors that encouraged Sharpe and his colleagues to change their direction and mandate. The Board's decision to enlarge the scope of its investigation was "not universally accepted and understood within the department [of National Defence]," but it proved an historic one, as the enlarged mandate and subsequent testimonies brought forth themes which had not been thoroughly discussed in Canadian military circles since the First and Second World Wars.⁸⁶ From August 1999 until its final report in January 2000, the BOI's proceedings were closely followed by the Canadian media, soldiers, and public, through both traditional mediums (excerpts aired on nightly newscasts) and a Croatia Board of Inquiry website kept up to date with all proceedings.⁸⁷

The Forgotten Past

Despite the Canadian military's experience with shell shock in the First World War, and battle exhaustion during the Second World War and Korean War, it was clear when Board testimonies began that the CAF was unprepared for the onslaught of psychological trauma faced in peacekeeping operations throughout the 1990s. Captain Kelly Brett, a physician and one of two Senior Medical Officers who oversaw Canadian medical staff in Croatia in 1993, testified there was considerable confusion regarding how to handle stress casualties: "There was confusion as to we don't know what to really do with them. We have social workers, we have

⁸⁵ Sharpe, *Croatia Board of Inquiry*, 37; Allan English, "Historical and Contemporary Interpretations of Combat Stress Reaction," prepared for the Board of Inquiry – Croatia and presented at the 1999 Conference on Defence Ethics, Ottawa, 2 November 1999.

⁸⁶ *Ibid.*, 29.

⁸⁷ It is important to note that in 1999 the Internet was not quite as pervasive as in the early twenty-first century, thus making the scanning of documents and availability of all Board information online quite a novel feat. According to Sharpe, the decision to make every aspect of the Board's work publicly available helped greatly to create a more cordial relationship with Canadian reporters. This was confirmed by Spellen in an interview with the author. See Sharpe, *Board of Inquiry*, 44-45; Spellen interview.

civilian psychologists. We don't really know what to do with it. People try, you know ... But I think it was just so foreign ... and we just weren't ready to deal with the post-deployment stuff that was going to fall out of these tours.”⁸⁸ Both military leaders and medical staff were largely unaware of traumatic stress or PTSD, and those who knew about combat stress did not associate such concepts with a peacekeeping milieu. That institutional blind spot was best encapsulated in the testimony of Major Dan Drew, 2PPCLI Officer Commanding, Delta Company during the Medak Pocket operation of September 1993. Drew summarized the situation thus:

Stress itself [was] not understood. It was a dead science in the Canadian army. We had not seen combat fatigue probably since Korea. So there was nobody around, no experts to be able to do deal with this issue. I don't know – I cannot speak on behalf of everybody else, but for myself I could not accept that we would have some sort of combat fatigue or, you know, some sort of posttraumatic stress syndrome or disorder because in our minds we had not been at war, okay. And yeah, we saw some bodies and we saw destruction and things like this. But probably I did not understand the significance of what this was -- the consequences that that would have on all of us later on.⁸⁹

Drew's conceptualization of combat stress and trauma, as with comrades from all ranks, reflected the fact that much of the Canadian military's acquired knowledge about psychological casualties was forgotten after the Korean War.⁹⁰ Colonel Ray Wlasichuk, a veteran of two Bosnia tours, maintained that, “I above anybody should have known everything I needed to know about post-traumatic stress disorder, and how a human being reacts to the situations we were faced with ... but we just didn't have that basic knowledge. It was available in psychiatric journals but it wasn't something that the military focused on.”⁹¹ There were, despite Drew and Wlasichuk's assertions, experts like Passey, up to date with current civilian psychiatric thinking

⁸⁸Testimony of Captain Kelly Brett, *Croatia Board of Inquiry*, September 22, 1999, vol. XI, 32.

⁸⁹Testimony of Major Dan Drew, *Croatia Board of Inquiry*, October 21, 1999, vol. XXI, 25.

⁹⁰ Allan English, “From Combat Stress to Operational Stress,” 12.

⁹¹ See “Ray Wlasichuk: Colonel,” in *The Chance of War*, 174.

about trauma, but they were few in number. Passey himself testified a week prior that the extent of the CAF's psychiatric team was five psychiatrists for over 60,000 troops, spread across bases all over Canada, with numerous bases having none.⁹² That problem was compounded, Passey said, by the reality that "not all of us [psychiatrists] have got training in this area [PTSD]."⁹³ He further expressed incredulity at the general lack of knowledge about PTSD in the CAF, even among medical staff. He declared: "I am still amazed there is people on the medical side that don't know anything about this situation, this disorder. And it is like, well, geez if we [physicians] don't know anything about it, what about the front line supervisors."⁹⁴ Confirmation of Passey's statement was provided by numerous other testimonies throughout the BOI. When asked about formal mechanisms for dealing with combat stress or PTSD, Lieutenant-Colonel Paul Wynnyk, a "G3" officer responsible for all aspects of training and operations within western Canada, could recall no programs in place during the early 1990s.⁹⁵ He chalked the situation up to the fact that the CAF had not "experienced it [PTSD] to the magnitude that we were experiencing it at the time."⁹⁶ Beyond revealing a dearth of understanding about psychological trauma, Board testimonies also demonstrated that decades-old ideas about mental illness signifying a weakness of character and femininity persisted.

The CAF of the 1990s, consisting of a modest-sized Regular Force and smaller Reservist element, was far different in character than the large citizen-soldier armies created in 1914 and 1939. Nonetheless, as in the past, Canadian soldiers in the post-Cold War period looked to military leaders for behavioural cues and adopted CAF cultural attitudes toward topics like

⁹² Testimony of Lieutenant-Commander Gregory Passey, *Croatia Board of Inquiry*, October 12, 1999, vol. XVI, 19.

⁹³ Ibid.

⁹⁴ Ibid., 18.

⁹⁵ Wynnyk was specifically responsible for Land Force Area West, which started in Manitoba and ran westward to British Columbia.

⁹⁶ Testimony of Lieutenant-Colonel Paul Wynnyk, *Croatia Board of Inquiry*, September 29, 1999, vol. XV, 10.

proper manliness and soldiering.⁹⁷ Far more so than in civilian society, the chain of command ensured that doctrine and attitudes were shaped from the top down. Military culture also gave officers at all levels significant power to resist change and punish thoughts and actions outside the norm.⁹⁸ Creating the proverbial “band of brothers” required a starker delineation between acceptable and unacceptable behaviour than that used in civilian society. Use of the term “suit,” utilized by CAF members to separate those in the CAF/DND who were part of the organization but not one of “us,” provided just one example of how military members defined who was inside and outside of that band.⁹⁹ Board testimonies confirmed that despite numerous changes in Canadian society and the military post-1945, members of all ranks held beliefs about mental illness akin to their forebears several decades prior. Those afflicted with psychological difficulties were urged to suffer in silence, lest they face ostracism for stepping outside of accepted ideals. But as the number of ill and disaffected soldiers increased, the Board gave them a forum through which to finally break their silence and reveal how psychological trauma and CAF cultural attitudes about mental illness had affected their lives. The “shut up” culture had been so effective that for many soldiers, as with Mike Spellen, it was the first time they saw the true extent of the problem, and how many of their comrades were likewise unduly affected by peacekeeping experiences.

Stigma

Numerous discussions throughout the Croatia Board revolved around the stigma attached to illness of any sort – and particularly mental illness – in the military. Similar to militaries

⁹⁷ As Allan English argued in *Understanding Military Culture*, “Subordinates look to leaders for cues to appropriate behaviour and often emulate leader behaviour.” See English, *Understanding Military Culture*, 22.

⁹⁸ *Ibid.*, 14.

⁹⁹ One other example is “REMF,” short for “rear echelon mother fucker,” a term used in the US and Canadian militaries to identify those who never leave the forward operating base and/or those who work in ostensibly comfortable circumstances, instead of “in the field.”

around the world, the CAF prided itself on members' fitness and ability to deploy at a moment's notice, as well as their resilience under even the most extreme circumstances. That preparedness was how militaries ensured they were up to the difficult tasks dictated by civilian governments, including operations assigned with little forewarning. The strong sense of self determination that drove men and women in uniform, and the Forces as a whole, also acted as a shield against anything that deterred operational readiness.¹⁰⁰ That fitness culture had two inadvertent effects on traumatized peacekeepers in the 1990s. The first was that it created in many soldiers' minds a self-imposed stigma regarding their illness, leading them to deny or ignore a health problem until a "crash" occurred.¹⁰¹ During his Board testimony, Captain Bob Sparks, Chaplain and Senior Stress Coordinator with 2PPCLI in 1993, highlighted the hesitancy soldiers displayed about discussing mental health problems: "The ones that I would see would be ones that the problem had gotten so big that they couldn't hold on to it any more, where the wife was complaining about them waking up in the middle of the night and this kind of thing."¹⁰²

Greg Prodaniuk supported Spark's testimony and highlighted how the fitness culture and notions of loyalty to the regiment worked against illness, persuading soldiers to carry on despite mental difficulties: "[Y]our behaviours are outside the norm. Your efforts are outside the norm. Get back on it. Get back in the run. Get back into the pack' ... [T]he shame ... that we bring upon ourselves, those stigmas that we put on ourselves, those self-imposed stigmas, were pretty powerful. You were pretty conditioned to do that."¹⁰³ Mike Spellen likewise emphasized the immense power of military culture to shape soldiers' mental processes. The voluminous number of testimonies and off-the-record discussions revealed to the Board that, "Most of these guys

¹⁰⁰ Prodaniuk interview.

¹⁰¹ See aforementioned interview testimony from Westholm, Godin, and Prodaniuk, as well as Dallaire's story.

¹⁰² Testimony of Captain Robert Sparks, *Croatia Board of Inquiry*, September 21, 1999, vol. X, 32.

¹⁰³ Prodaniuk interview.

initially didn't know that there was something going on with them; or they were in denial.”¹⁰⁴

The stigma attached to mental illness was sufficiently strong enough to prevent many from seeking help, even despite losing their family and career, ending up on the street, or deciding upon suicide.¹⁰⁵

Beyond the self-imposed stigma soldiers attached to their condition, the fitness culture's second consequence extended to how CAF members perceived their comrades' vulnerability. Board testimonies indicated that many decades after Sir Andrew Macphail described shell shock as a display of femininity, an altered but still powerful military masculinity operated against psychological “weakness” and PTSD. Captain Kelly Brett summarized the situation thus: “The military still has a very macho attitude and certainly in the army it is a male dominated culture and people don't want to come forward. They just don't want to come forward and admit a weakness ... And it is [both] the men and officers, it doesn't matter.”¹⁰⁶ In other words, weakness was not tolerated. Greg Prodaniuk described the language used in the 1990s against those showing signs of vulnerability as “blunt” and sometimes “brutal,” implying that a soldier reporting psychological problems was just a “weak piece of shit.”¹⁰⁷ As stated in the quotation at this chapter's beginning, military parlance was also infused with gendered terms such as “weak sister” to describe those who displayed physical or psychological vulnerability.¹⁰⁸ Dr. Mark

¹⁰⁴ Spellen interview.

¹⁰⁵ Ibid; One Board member actually recognized a homeless man on the streets of Ottawa as a fellow soldier who had served in Croatia during the early 1990s. The latter was released from the CAF and suffered from severe mental health problems. See Richardson et al., “Operational Stress Injury Social Support,” 57.

¹⁰⁶ Testimony of Captain Kelly Brett, 31.

¹⁰⁷ Prodaniuk interview.

¹⁰⁸ The term “weak sister” is an Americanism that dates back to the mid-nineteenth century, and unsurprisingly, was used to describe a member of a group that was perceived as a weak link. In the 1877 *Dictionary of Americanisms* the author defined a weak sister simply as “a person that cannot be relied upon.” He used as an example an 1861 quotation from the *New York Tribune* newspaper that discussed the existence of white Unionists in the South: “The rebels assert that the Union has no friends at the South. The assertion is false. There are white Unionists there, but they are *weak sisters*, —overawed, terrorized, silenced.” Evidently, at some point the term made its way into Canadian English as well. See John Russell Bartlett, *Dictionary of Americanisms: A Glossary of Words and Phrases Usually Regarded as Peculiar to The United States* (Boston: Little, Brown and Company, 1877), 742.

Tysiaczny, Regional Surgeon at Air Command Headquarters in Winnipeg in 1993, described the reticence soldiers of all ranks displayed about undergoing CISD or discussing mental illness. Tysiaczny faced an “uphill battle” when he attempted to organize CISD sessions with 2PPCLI a month after its return from Croatia.¹⁰⁹ The reason, he said, was that “it [CISD] was seen by some as a sort of ... airy-fairy, not very macho thing.”¹¹⁰ Like the John Wayne figure, “real” men embraced stoicism when facing adversity, instead of resorting to “feminine” behaviour such as venting their feelings. When queried about whether resistance came from both the “the combat arms side” and the “medical side,” Tysiaczny responded that, “It was every side.”¹¹¹ Mike Spellen further probed the source of resistance, asking Tysiaczny about the participation rate he received from “upper management, senior NCOs and officers.”¹¹² In a sign that military leaders were less than enthusiastic about encouraging the rank and file to express their feelings or problems, Tysiaczny affirmed that, “We [CISD specialists, social workers, etc.] handled more the [lower] ranks than the officers. We had had a couple of officer groups and tended to have only junior officers present.”¹¹³

The stigma attached to psychological vulnerability was present in all ranks and trades. Mike Spellen recalled that the few soldiers who had the courage to come forward about mental difficulties were quickly cast off by their peers.¹¹⁴ Those diagnosed with a mental disorder found themselves on the outside of the circle, as their friends “all of a sudden wouldn’t socialize with them.”¹¹⁵ Higher up, many in the upper chain of command quite simply “thought it [PTSD] was

¹⁰⁹ Testimony of Dr. Mark Tysiaczny, *Croatia Board of Inquiry*, November 9, 1999, vol. XXIV, 15.

¹¹⁰ Ibid.

¹¹¹ Ibid., 16.

¹¹² Ibid., 9.

¹¹³ Ibid; Tysiaczny’s statement implied that they usually saw no one above the Army rank of Captain.

¹¹⁴ Spellen interview.

¹¹⁵ Ibid.

all bullshit.”¹¹⁶ Passey testified that when he started working with the PPCLI “some senior people” thought PTSD “was all garbage,” arguing instead that a high level of discipline and morale made their companies impervious to psychological casualties.¹¹⁷ Spellen remembered a private meeting with Chairman Sharpe and an anonymous colonel from the Van Doos Regiment.¹¹⁸ During the discussion, the colonel informed Spellen and Sharpe he had been diagnosed with PTSD by a civilian physician and was paying for treatment out of his own pocket so that he did not have to reveal the condition to his superiors.¹¹⁹ Passey testified that even amongst the infantry battalions, where there were considerable numbers of soldiers diagnosed with PTSD, “they are not very tolerant of this disorder. It’s like you get ostracized, you get marginalized.”¹²⁰ Master Warrant Officer Ed Larabie, a Reconnaissance Platoon Warrant Officer in Croatia in 1993, echoed Passey’s sentiments: “[T]here are loads of people out there that will not come forward because they are worried about ... the stigma attached to it and having to put up with their peers ... I still sit in the mess [hall] now and they start talking about ... ‘Oh, this guy is a loser.’ ‘He is an idiot.’ ‘He has lost his marbles.’”¹²¹

For those unwilling to accept the existence or extent of PTSD within the military, the issue was often perceived as a matter of honour. PTSD and mental illness were deemed a literal attack on manpower, operational effectiveness, and unit cohesion, but equally important, they were also a metaphorical attack on the Forces’ prestige. Sergeant Chris Byrne, 2PPCLI member who served in Croatia in 1993, explained how notions of honour encouraged hostility against health problems that implied cowardice or weakness: “You see the people that are the cause of

¹¹⁶ Ibid.

¹¹⁷ Testimony of Greg Passey, 17; Doctors in the 2 Canadian Division made similar claims about preparation, training, and discipline acting as a shield against stress casualties prior to fighting in France in 1944. That argument proved unfounded. History repeated itself in the 1990s. See Shephard, *A War of Nerves*, 254.

¹¹⁸ Spellen interview.

¹¹⁹ Ibid.

¹²⁰ Testimony of Lieutenant-Commander Greg Passey, 18.

¹²¹ Testimony of MWO Ed Larabie, *Croatia Board of Inquiry*, October 18, 1999, vol. XIX, 13.

what is wrong with the system are afraid that the honour of the soldiers of the past or regiment itself or the battalion itself is going to be dishonoured in some way.”¹²² Ed Larabie’s testimony before the Board likewise demonstrated that penetrating internalized cultural values about duty to the regiment was a herculean task. He affirmed: “It’s a stigma that I don’t know you can ever get over ... I guess it is a soldier’s honour or whatever but you can’t be perceived to be weak.”¹²³ PTSD, like other afflictions, tainted both individual and regimental honour, and, as expressed by many soldiers throughout the centuries, “those that weren’t there have no idea what it [soldier’s honour] is about.”¹²⁴

CAF members were reluctant to do anything to jeopardize their honour, or that of the military, and quickly closed ranks when approached by those from outside the circle. A soldier’s loyalty was (and is) first and foremost to the battalion, and more specifically to those with whom they shared front-line experiences — colloquially put, their “buddies.”¹²⁵ According to Kelly Brett, when a Critical Incident Stress team arrived in Croatia, a colonel forbade them from seeing his soldiers; a move Brett approved of, even as a doctor, because “we understood ... you can’t just fly a team in from Canada without any [front-line/military] experience.”¹²⁶ Back in Canada, Mark Tysiaczny knew that CISD was most effective at penetrating soldiers’ reluctance to speak out when conducted by “a peer counsellor who is from the group,” but lamented that “it took some time before that philosophy was accepted.”¹²⁷ Master Warrant Officer Randy Northrup, 2PPCLI Combat Support Company Sergeant Major in Croatia in 1993, recalled that a few

¹²² Testimony of Sergeant Christopher Byrne, 8.

¹²³ Testimony of MWO Ed Larabie, 13.

¹²⁴ Ibid.

¹²⁵ This point has been made a plethora of times in texts going back to ancient times. Recently it was stated quite poignantly by journalist/documentarian Sebastian Junger in his book *War*, written during his time “embedded” with U.S. soldiers in the Korengal Valley in Afghanistan from 2007-2008. Junger discovered, like many before him, that soldiers’ loyalty was primarily to their comrades, and especially those with whom they shared the experience of battle. See Sebastian Junger, *War* (Toronto: Harper Collins, 2010), passim, esp. 232-245.

¹²⁶ Testimony of Captain Kelly Brett, 34.

¹²⁷ Testimony of Dr. Mark Tysiaczny, 11.

soldiers were willing to speak with CISD counsellors but, “a lot of guys, pure rebuff. [They declared] ‘Didn’t bother me at all.’”¹²⁸ Northrup indicated that most men in uniform simply did not trust CIS teams, and that treatment success was more likely to come “behind their house having a barbecue with a beer,” rather than trying to discuss something perceived as a “manhood problem” in a formal setting.¹²⁹

Pension and Career Concerns

In addition to concerns about social shunning, dishonouring the regiment, or being viewed as a lesser man, many soldiers’ desire to hide their injury was further fuelled by career concerns. The military constituted not just soldiers’ social world, it encompassed their economic one as well. Those with families, in particular, wore several hats as husband, father, and provider.¹³⁰ Similar to their civilian counterparts, Forces members sought job stability and a future retirement life secured by a pension. But unlike civilians, CAF members were subject to the “universality of service” principle. Also known as the “soldier first principle,” universality of service made it the requirement of military members to be “operationally employable” and “operationally deployable,” as well as able to perform the functions of their specific occupation or “the more generic type functions of their environment.”¹³¹ Soldiers had to be physically and mentally fit to serve their country at a moment’s notice and able to carry on their trade. Bosnia veteran Fred Doucette laconically summarized the universality principle as, “No deploy, no

¹²⁸ Testimony of MWO Randy Northrup, *Croatia Board of Inquiry*, September 20, 1999, vol. IX, 19.

¹²⁹ Ibid.

¹³⁰ Christopher Dummitt and Susan Holloway, “Canadian Manhood(s),” in *Canadian Men and Masculinities*, 127.

¹³¹ Testimony of Karol Wenek, *Croatia Board of Inquiry*, November 24, 1999, vol. XXVIII, 6; As discussed by Wenek in her Board testimony, this principle was even reflected in an amendment to the *Canadian Human Rights Act* which makes reference to the principle and interprets it as the liability of CAF members to perform “whatever duties they may be lawfully be [sic] called upon to perform.” This quite clearly separates the onus placed on soldiers’ during service from that of civilians. See *ibid.*

employ.”¹³² In a military undergoing significant funding and troop reductions throughout the 1990s, those deemed in violation of the universality principle were at greater risk of being released. Those suffering from psychological injuries were thus between the proverbial rock and a hard place as they battled both inner demons and fears over losing their career and calling.

Chairman Sharpe and the Croatia Board members sensed early in the proceedings that not only were many soldiers suffering in silence, but that numerous others were being – and had been – released from the Forces early and denied a pension.¹³³ Sharpe, later described by Carol Off as a “guardian angel” to injured soldiers and veterans, made no secret of his disgust at what he deemed an archaic and broken system.¹³⁴ He did not tread lightly, and placed his career on the line in a number of public criticisms about how ill soldiers were treated.¹³⁵ In a December 1999 *Globe and Mail* article, the Board’s report was quoted as terming the treatment of ill soldiers “a disgrace.”¹³⁶ The report affirmed that the situation “cannot be allowed to continue,” and reiterated the Board’s belief that stress illnesses were neither a fabrication nor a sign of weakness.¹³⁷ According to Sharpe, for his outspokenness the DND Assistant Deputy Minister of Public Affairs sought, without success, a court martial against him for bringing disrepute to the military.¹³⁸

As it did with its investigation into the CAF’s socio-cultural milieu, the Board delved into the organizational factors that shaped how and why psychological injuries were treated as unworthy of monetary restitution by the CAF and Veterans Affairs Canada (VAC). Sharpe and

¹³² Doucette, *Empty Casing*, 207.

¹³³ Sharpe, *Croatia Board of Inquiry*, 6-7.

¹³⁴ Off, *The Ghosts of Medak Pocket*, 257.

¹³⁵ *The Globe and Mail*, 11 August 1999; Sharpe headed a board of inquiry in the mid-1980s into the suicide of a young soldier. The inquiry found fault with a number of the man’s superior officers, and demonstrated that Sharpe was unafraid of rocking the boat if necessary.

¹³⁶ *The Globe and Mail*, 17 December 1999.

¹³⁷ Ibid.

¹³⁸ Sharpe, e-mail message to author, October 10, 2014.

his colleagues discovered that the traditional medical model persisted within both organizations, emphasizing the legitimacy of physical over mental problems.¹³⁹ Since the type of injuries stemming from peacekeeping repeatedly did not fit that model, numerous soldiers were treated as malingerers unqualified for a military pension.¹⁴⁰ Mental injuries were also sidestepped by VAC as something not on the list of injuries covered, and afflictions that soldiers could not prove were sustained in a “special duty area.”¹⁴¹ Lastly, the disability insurance program CAF members paid into, the Service Income Security Insurance Plan (SISIP), had a different definition of “medically unfit” than the CAF. The result was that soldiers could be released from the Forces on medical grounds, but still denied a pension by SISIP with the justification that they were not proven “sufficiently disabled.”¹⁴² In short, the organizational deck was stacked against injured troops, and especially those whose injuries were not necessarily visible to the naked eye.

Board testimonies also revealed that troops faced a labyrinthine and slow-moving process in their fight for restitution. Bernard Butler, acting Director of Pension and Operational Services for VAC, testified before the Board that prior to 1995 veterans making a pension claim waited an average of eighteen months for a decision in their case.¹⁴³ After a series of reforms, Butler happily reported that the turnaround time was down to approximately five to six months.¹⁴⁴ Nevertheless, whatever improvements were made in response times were offset by the organizational factors that made proving a claim, according to retired Colonel George Oehring,

¹³⁹ Sharpe, *Croatia Board of Inquiry*, 6.

¹⁴⁰ Ibid.

¹⁴¹ Ibid., 7; A peacekeeping operation or multinational operation such as the Gulf War were, since 1949 deemed “special duty areas,” as opposed to operations within Canada. Those participating were entitled to pensionable benefits in the case of injury or death; In fact, VAC did not even consider peacekeepers to be veterans after they left the Army. See J.L. Granatstein, *Canada’s Army: Waging War and Keeping the Peace*, Second Edition (Toronto: University of Toronto Press, 2011), 397 and 397n.

¹⁴² Sharpe, *Croatia Board of Inquiry*, 7.

¹⁴³ Testimony of Bernard Butler, *Croatia Board of Inquiry*, 9.

¹⁴⁴ Ibid.

“a very, very big uphill battle to fight.”¹⁴⁵ Suspicions about VAC’s willingness to help psychologically injured veterans were further supported by specialists’ anecdotal evidence. Passey related to the Board a story of a peacekeeping veteran with PTSD who became an alcoholic *after* his diagnosis, ostensibly in part because of his illness. Passey indignantly testified that, “Veterans Affairs basically said, ‘Well, he has got an alcohol problem. We are not paying for that.’ And it is like ... The person has got PTSD. He is abusing the alcohol.”¹⁴⁶

One particularly poignant testimony regarding problems with “the system” came from Master Seaman Wade Kelloway, a Preventive Medical Technician in the Balkans from April to October 1994. Kelloway bluntly told Board member Lieutenant-Colonel Sutherland early in the proceedings that when dealing with health issues “I prefer to deal with [the] civilian side of the house, rather than the system.”¹⁴⁷ Later in his testimony Kelloway further expounded on his discontent, saying that after experiencing health problems “over in the Medical Unit ... they didn’t give two rats about me.”¹⁴⁸ But the most scathing comments about the CAF medical system came during the last moments of Kelloway’s appearance. When Chairman Sharpe reiterated that “part of our mandate here is to try and make sure that we take care of people properly when they come back,” Kelloway quickly interjected “And they don’t sir ... I see it all the time ... I’m a medical person in a medical system and I’m not even taken care – I’m pushed aside.”¹⁴⁹ Coming from a member intimately knowledgeable of the CAF medical milieu, Kelloway’s statement was all the more indicative of systemic problems. Consequently, many in the Forces chose a similar route as Kelloway and the anonymous Van Doo colonel, seeking

¹⁴⁵ Testimony of Colonel George Oehring (ret.), *Croatia Board of Inquiry*, November 10, 1999, vol. XXV, 23.

¹⁴⁶ Testimony of Greg Passey, 14.

¹⁴⁷ Testimony of MS Wade Kelloway, *Croatia Board of Inquiry*, September 24, 1999, vol. XIII, 5.

¹⁴⁸ *Ibid.*, 16; Kelloway’s problems were severed from the testimony document but PTSD was implied several times throughout, particularly in Kelloway’s statement that “this is all related to what I’ve been through in Croatia.” See *ibid.*

¹⁴⁹ *Ibid.*

treatment away from their posted base. Major Darrell Menard, a doctor who worked in the Directorate of Medical Policy at the National Defence Medical Centre in the 1990s, argued that given the financial implications and his belief that “there is no accommodation left in the system for them [soldiers] if they have a problem that won’t allow them to deploy,” it was “not hard to understand” why many troops sought help outside of the military.¹⁵⁰

More than any other testimony, that of Colonel Oehring, former Commander of Sector South in Croatia from September 1993 to August 1994, summarized numerous soldiers’ problems with the CAF medical system and VAC’s treatment of injured veterans. Late in his Board testimony Oehring lamented:

We subject each embarking soldier to a medical screening and/or examination as a precondition to deployment, and then when they return in other than the physical or mental shape in which they left we seem not to accept that the cause is attributable to that deployment. This is not only unfair; it is immoral. We seem to be so frightened that one man or one woman will cheat the system that we make it very difficult for any to receive the compensation and/or treatment the country owes them. In this regard, we have made our otherwise excellent medical system the watchdogs and agents of the Pension Board rather than the advocates of the soldiers that they should be.¹⁵¹

Oehring’s testimony, and the testimonies from soldiers of all ranks, spotlighted certain issues such as “attributability” that remained a problem eighty years after the end of the Great War. For all of the changes during the intervening decades and conflicts, the onus was still on soldiers and veterans to definitively prove their injury was attributable to service; a task made immensely more challenging for those who, like their First and Second World War counterparts, brought home seemingly invisible wounds. Fear of individuals “cheating” the system, foremost in pension officials’ minds during the post-1918 and 1945 periods, were still present in military

¹⁵⁰ Testimony of Darrell Menard, *Croatia Board of Inquiry*, November 25, 1999, volume number missing from original document, 14.

¹⁵¹ Testimony of Colonel George Oehring, 22.

leaders' and VAC officials' minds in the 1990s. CAF doctors were also reluctant to acknowledge psychological illnesses. Sharpe explained in his retrospective book about the Croatia Board proceedings that "Doctors in uniform, particularly senior officers, are far more sceptical than civilians when it comes to stress-related injuries."¹⁵² Fear and scepticism mixed with traditional understandings of combat stress, proper soldiering, and manhood to ensure that psychologically injured peacekeepers and veterans encountered many of the same difficulties as their forebears when seeking medical treatment or a pension.

A sadly informative case was that of Phil Tobicoe, First Nations member and Croatia veteran with a long family history of military service in the American, British, and Canadian armies.¹⁵³ Tobicoe, who developed inexplicable psychosomatic symptoms after Croatia, was turned down for a pension.¹⁵⁴ He spoke for many soldiers when he expressed that he simply wanted to serve his country and be granted a pension for injuries incurred as a result of that service: "I want to do my 20 years [in the military]. I want to do it proudly because I am Missassaugas [sic] of the Credit [River] ... and a First Nations Indian. I am very proud of my service and ... have family [history] in the American army, the British army, the Canadian army and we are very proud. We just want to make sure we are looked after."¹⁵⁵ Tobicoe's circumspect response to his predicament reflected the mixture of anger, disappointment, and confusion many soldiers felt towards the military and VAC.

As the Board of Inquiry progressed, it was not just front-line soldiers and officers who expressed anger at how the system was failing men and women in uniform. During SISIP President W.D. Roberts' testimony, Chairman Sharpe became so angry at the former's "callous

¹⁵² Sharpe, *Croatia Board of Inquiry*, 74.

¹⁵³ Off, *The Ghosts of Medak Pocket*, 256.

¹⁵⁴ Ibid.

¹⁵⁵ Testimony of Master Corporal Phil Tobicoe, *Croatia Board of Inquiry*, November 9, 1999, vol. XXIV, 24.

and uncaring attitude” and “pride in the fact that he was able to save the insurance company money by denying soldiers’ claims” that he was unable to thank Roberts for his Board appearance; the only time during the Board’s proceedings in which such an event occurred.¹⁵⁶ Sharpe’s anger was partially fuelled by Roberts’ appearance before the Board in a “thousand dollar suit and Italian leather shoes,” as well as his apparent mirth shown when “denigrating the ‘unwarranted’ requests from near destitute soldiers.”¹⁵⁷ Sharpe firmly believed that Roberts was “proud of his ability to find ways to deny [pension] coverage.”¹⁵⁸ Mike Spellen described Roberts as akin to a “washed up used car salesman” and stated that he had never seen Sharpe mad in many years, “except for that day.”¹⁵⁹ For his part, Spellen stated matter-of-factly that if he was not a Board member he “might have” punched Roberts.¹⁶⁰

Social Support

After returning to Canadian soil most troops were preoccupied with getting back to the basic comforts of life and seeing loved ones. Sergeant Gregory Goudie’s thoughts reflected what numerous colleagues felt: “[W]e just want to see the wife, you know, get a bottle of bourbon down range.”¹⁶¹ Above all else, they were happy “just to get home.”¹⁶² The initial euphoria of being home caused most troops to ignore or suppress thoughts about the tour. Nevertheless, after settling in they discovered they were relatively invisible both on- and off-base. Given the

¹⁵⁶ G.E. Sharpe, e-mail message to author, November 4, 2014; Sharpe’s recollection of Roberts’ testimony is supported by the testimony document, which indeed shows that Major Caron, rather than Chairman Sharpe thanked Roberts for his Board appearance. See Testimony of W.D. Roberts, *Croatia Board of Inquiry*, November 25, 1999, vol. XXVII, 25.

¹⁵⁷ Ibid.

¹⁵⁸ Ibid.

¹⁵⁹ Mike Spellen interview; Spellen stated to the author that part of the Board’s frustration lay in the fact that Roberts seemed to have almost dictatorial power over the outcome of veterans’ cases (a point also supported by the testimony transcript), and that he also seemed to revel in it.

¹⁶⁰ Ibid.

¹⁶¹ Testimony of Sergeant Gregory Goudie, *Croatia Board of Inquiry*, November 25, 1999, vol. XXIX, 8.

¹⁶² Ibid.

aforementioned socio-political climate and “shut up” culture pervading the CAF during the 1990s, soldiers returning from peacekeeping tours often found that nobody knew or cared about what they had been through.¹⁶³ Despite the fact that senior UN commanders praised the performance of Canadian peacekeepers in the Balkans, and UNPROFOR Commander (June 1993 to March 1994) General Jean Cot awarded the PPCLI a special UN citation, most Canadians in and out of uniform knew little about the UNPROFOR mission and its challenges.¹⁶⁴ In fact, it was not until nine years after the Medak Pocket battle, on 1 December 2002, that Governor General Adrienne Clarkson finally presented 2PPCLI members with a special citation, admitting that “your country did not recognize you at the time.”¹⁶⁵ BOI testimonies captured the manner in which stigma and CAF culture created socio-economic difficulties for injured soldiers. They also revealed the intangible but nonetheless important ways that a lack of military and civilian support exacerbated psychological injuries as well. Psychological trauma and PTSD had significant medical and financial dimensions. But there were also moral and spiritual dimensions to how peacekeeping experiences were rationalized by troops returning to a Canada that looked different after witnessing the horrors of ethnic cleansing and other traumatic events. Board testimonies and the modest primary literature on 1990s Canadian peacekeeping provide a window into how soldiers experienced the psychological aftermath of service, and how a perceived lack of support affected the meanings they attached to that service.

One of the biggest obstacles Canadian peacekeeping veterans faced, especially those suffering from psychological difficulties, was finding a comrade or close friend with whom to rationalize their experiences. Croatia and Bosnia veteran Sergeant Peter Vallée from the Van Doos found it difficult to speak about his experiences, especially because most civilians were “so

¹⁶³ Sharpe, *Croatia Board of Inquiry*, 3-4.

¹⁶⁴ Ibid; Off, *The Ghosts of Medak Pocket*, 231-232.

¹⁶⁵ Quoted in Off, *The Ghosts of Medak Pocket*, 274.

clueless about all of it it's almost laughable.”¹⁶⁶ Occasionally people asked Vallée what it was *really* like to participate in peacekeeping operations, but he discovered that few thought of it as anything more than a “flash on the news.”¹⁶⁷ Vallée decided the best course of action was to just avoid the subject entirely: “I won’t talk about it, *ever*, because immediately you’re the outcast. It’s not a great icebreaker at parties.”¹⁶⁸ Similar to other peacekeeping veterans, Vallée felt a vast gulf between the civilian and military worlds, since for the former group peacekeeping operations were, simply put, “not part of their reality.”¹⁶⁹

Master Warrant Officer Randy Northrup noticed a “tell-tale sign” that numerous soldiers were attempting to stave off the traumatic memories haunting them. Unable to rationalize the immensely troubling evidence of ethnic cleansing and other scenes in the Balkans, many turned to black humour to downplay the effect such experiences had on their mind.¹⁷⁰ One example of that humour in action during the UNPROFOR mission occurred when Canadian soldiers spray painted the words “UN Protected” in UN blue on a group of chickens from a destroyed farm.¹⁷¹ While their actions symbolically – and sarcastically – expressed what many soldiers felt about the mission’s effectiveness at protecting civilians, the joke’s darker implication was that the

¹⁶⁶ John Wood, “Sergeant Peter Vallée,” in *The Chance of War*, 213.

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ Off, *The Ghosts of Medak Pocket*, 207; The use of dark humour during wartime or other harrowing experiences to lighten the mood and deal with overwhelming events is well documented. See, as just one example, the beginning of Antony Beevor’s work on the Battle of Berlin in 1945: Antony Beevor, *The Fall of Berlin 1945* (Toronto: Penguin Books, 2003), passim, esp. chapter one; In the Canadian context, veterans at Sunnybrook Hospital in Toronto reported that humour was one of the ways they made it through the Second World War. After the War, it was used to suppress the more horrific moments. One veteran stated: “Mostly we joke about the war. That’s how we handle it ... We look at the jolly side, the women we met, not the cruel side.” See *The Toronto Star*, 7 November 2009.

¹⁷¹ Testimony of Lieutenant (Navy) M.J. Brown, *Croatia Board of Inquiry*, September 23, 1999, vol. XII, 49; Another example, among many, described by Carol Off, was the naming of a Reservist’s truck as “the Grim Reaper,” since the man’s surname was Grimmer and his job at one point involved transporting dead bodies. See Off, *The Ghosts of Medak Pocket*, 207.

chickens were literally “the only signs of life” in the area.¹⁷² Many troops brought that dark humour tactic home with them. Northrup described to the Board how soldiers, several years after the events, still used humour to shrug off evidently troubling thoughts: “When you talk to individuals that were in the mortar groups and the sweep teams and when you talk about certain [events] ... they go right to black humour. It’s immediate defense ... the black humour, for people who are still fighting off the issue ... They try to laugh it away. But you can tell it still bothers them.”¹⁷³

Given the social, financial, and career risks associated with venting to the wrong person, most soldiers simply kept quiet about their thoughts except in the presence of someone who had “been there.” Naval Lieutenant Michael Brown, a Roman Catholic Chaplain to 2PPCLI from April to October 1993, testified about the emotional weight peacekeeping veterans carried long after their return: “I have had guys over the past six years who have – I guess maybe it is a typical thing. When you get together, you meet in the airport ... or whatever it is and you go off for a beer and they just – it starts to come out. Because they actually found someone who they can tell the story [to] and the person’s eyes don’t glaze over.”¹⁷⁴ As with numerous comrades, Brown felt he could not speak about his experiences to someone who had not been in theatre, because they did not “get it.”¹⁷⁵

In Brown’s estimation, honouring peacekeepers was a moral responsibility the military and Canada failed in; a failure that carried psychological consequences for veterans. He angrily testified: “Have we honoured what they have gone through? No ... We have not honoured their sacrifice. We have not given them what they need ... [P]art of that process in honouring what

¹⁷² Ibid.

¹⁷³ Testimony of MWO Randy Northrup, 21.

¹⁷⁴ Testimony of Lieutenant (Navy) M.J. Brown, 55.

¹⁷⁵ Ibid.

they have done is to normalize it for them ... And by doing that [not honouring them] we have added ... to their stress.”¹⁷⁶ Colonel Jim Calvin, Commanding Officer of 2PPCLI during the Medak Pocket battle, likewise believed the dearth of attention paid to peacekeepers’ efforts made an already difficult psychological situation worse. He stated that “when we came home, there was no recognition of what we had achieved even though if you talked to anybody [other national contingents] in UNPROFOR ... they thought we were all bloody heroes ... We came back here and it was just you are done ... There was very little assistance and I would have to say a certain amount of an uncaring attitude that was put toward us.”¹⁷⁷

Calvin knew firsthand how little the military and DND seemed to want to know about the Medak Pocket, since it was not until April 1998, almost five years after the battle, that a delegation of his soldiers was finally allowed to conduct a presentation about Medak to a Parliamentary committee on defence.¹⁷⁸ Calvin was also ordered a year earlier to break off a promised interview about Medak with *Ottawa Citizen* reporter David Pugliese; an order that was only rescinded because Pugliese threatened to change his story to reflect Calvin’s forced silence.¹⁷⁹ Like Lieutenant Brown, Calvin attributed harmful effects to the CAF/DND’s attempts to shield the public from any unpalatable peacekeeping experiences. He argued that the “uncaring attitude” demonstrated by both departments and lack of recognition “certainly might have exacerbated things.”¹⁸⁰ Calvin believed his soldiers had lived “ten years in that six months [of UN service],” a belief given credence by Sergeant Chris Byrne’s affirmation that “what I witnessed during our stay in Medak would haunt me forever.”¹⁸¹

¹⁷⁶ Ibid., 58.

¹⁷⁷ Testimony of Colonel Jim Calvin, *Croatia Board of Inquiry*, September 16, 1999, vol. VII, 142.

¹⁷⁸ Taylor and Nolan, *Tested Mettle*, 231.

¹⁷⁹ Ibid.

¹⁸⁰ Testimony of Colonel Jim Calvin, 142.

¹⁸¹ Testimony of Sergeant Christopher Byrne, 7.

Lieutenant-Colonel Craig King, 2PPCLI Alpha Company Commander in Croatia from July to September 1993, discussed peacekeeping's moral quandaries and the existential questions soldiers battled with during and after their tour. One of the most troubling questions was whether or not Canadian soldiers had done all they could for civilians caught in the crossfire and targeted for ethnic cleansing. Since Canadian troops ostensibly operated as part of a "protection force," some felt they had in fact failed to protect anyone.¹⁸² King testified before the BOI that certain questions, such as "What were we doing? Could we have done more for these people?" plagued soldiers' minds.¹⁸³ King told the Board that "there is a sort of moral plane that you start to look at these things and start to ask yourself these sorts of questions."¹⁸⁴ For numerous soldiers such as Sergeant Byrne, witnessing the aftermath of ethnic cleansing caused them to question the entire purpose of their mission and sacrifices. He declared: "We were not peacekeepers. We were not soldiers. We were nothing over there. Nobody knew exactly what we were supposed to be doing and what we weren't supposed to be doing ... We weren't to establish peace because there was no peace to begin with."¹⁸⁵ Captain Bob Organ, a CISD trained Regimental Chaplain to 2PPCLI, emphasized the spiritual and existential dilemmas that disturbed numerous soldiers after returning from the Balkans: "I think you call into question what it means to be human ... if there's a God and if there's a God, what is that God doing? You're confronted with evil and I think you've got to work that through in order to regain an equilibrium and feel that you can re-invest in life."¹⁸⁶ Unfortunately, challenging spiritual and moral questions were made all the more difficult to rationalize when peacekeepers returned home to find their missions were neither widely known nor honoured by the military and civilian society.

¹⁸² Testimony of Lieutenant-Colonel Craig King, *Croatia Board of Inquiry*, October 15, 1999, vol. XVIII, 23.

¹⁸³ Ibid.

¹⁸⁴ Ibid.

¹⁸⁵ Testimony of Sergeant Christopher Byrne, 7.

¹⁸⁶ Testimony of Captain John Organ, *Croatia Board of Inquiry*, September 24, 1999, vol. XIII, 7.

Reserves

Although Regular Force members encountered difficulties finding comrades to trust with their most intimate thoughts and troubles, Reservists, who made up a significant number of the Canadian UNPROFOR contingent (and other peacekeeping contingents), were up against even greater challenges if they developed psychological problems or simply needed a colleague's ear. Budget concerns were foremost in military leaders' minds, so upon a Reservist's return from peacekeeping duties they were hurriedly rushed through post-deployment medical checks and sent home before their contractual time elapsed.¹⁸⁷ Colonel Calvin said that troops were, for the most part, "scattered to the winds."¹⁸⁸ Chief Warrant Officer D.F. DesBarres, a platoon Second in Command with 2PPCLI in Croatia in 1993, described the post-deployment situation thus: "A reservist arrived in Winnipeg, walked by somebody who was filling out a medical questionnaire to make sure you had your ten toes and ten fingers and that your head was on the top of your body ... and a day or two later you found yourself in an airport in Halifax, St. John's, Newfoundland, Vancouver and all the way across the country."¹⁸⁹ When the Croatia Board first convened several years later, it quickly became evident that the CAF did not even have a central information source on which Reservists had served in the Balkans.¹⁹⁰ Such embarrassing revelations seemed to indicate that Reservists and post-deployment issues were not at the top of the military's priority list, and added to many soldiers' suspicions about "the system."¹⁹¹

From evidence provided during the BOI about Regular Force members' psychological difficulties, it stood to reason that Reservists must also be facing similar issues. Mike Spellen

¹⁸⁷ Spellen interview.

¹⁸⁸ Testimony of Colonel Jim Calvin, 122.

¹⁸⁹ Testimony of CWO D.F. DesBarres, *Croatia Board of Inquiry*, October 19, 1999, vol. XX, 10.

¹⁹⁰ Sharpe, *Croatia Board of Inquiry*, 46.

¹⁹¹ Ibid.

described how Reservists were provided even fewer opportunities to rationalize their tour and seek comrades' support before being sent home. He recalled: "Now we're going home ... before the second plane [with Regular Force members] lands, some of these guys [Reservists] are already sent home to Pump Handle Junction, Alberta and Tuna Lake, Newfoundland. And they never got to see each other or socialize with each other ... and that had an effect on guys."¹⁹²

Retired Master Warrant Officer Gerald Boyle echoed Spellen's assessment, saying that Reservists were "just dispersed," and "some people were on flights that night or the next day and you never [sic] seen them again."¹⁹³ Even Regular Force members were not necessarily guaranteed time to readjust and work through their experiences with colleagues before dispersal. Warrant Officer Geoff Crossman, member of a mortar platoon and sweep team that cleaned up civilian bodies after Croatian ethnic cleansing in 1993, was quickly posted from Calgary to Toronto after his homecoming. His rapid dispersal meant that, like many Reservists, he found himself far from his comrades and "with no one to talk to" about the harrowing experiences he endured.¹⁹⁴

Corporal Anita Kwasnicki, a Reservist from Saskatoon who served with 2PPCLI in Croatia in 1993, was in a uniquely challenging social position as the only female infanteer in her battalion. She too, like her male colleagues, remained in Winnipeg less than a week after returning before being sent home to Saskatchewan. Although describing herself as in good health, Kwasnicki stated to the Board that she was unable to access any formal (or informal) social or medical support if necessary, since both were only available at CFB Moose Jaw, over two hours' drive from Saskatoon.¹⁹⁵ After joining the Regular Force and moving back to

¹⁹² Spellen interview.

¹⁹³ Testimony of MWO Gerald Boyle (ret.), *Croatia Board of Inquiry*, September 23, 1999, vol. XII, 8.

¹⁹⁴ Testimony of WO Geoff Crossman, *Croatia Board of Inquiry*, October 18, 1999, vol. XIX, 11-12.

¹⁹⁵ Testimony of Corporal Anita Kwasnicki, *Croatia Board of Inquiry*, October 18, 1999, vol. XIX, 11.

Winnipeg in 1997, Kwasnicki was still unable to discuss her experiences or socialize with her peers, since most were “a whole bunch of 18-year-old guys” she could not relate to.¹⁹⁶ Even after another woman joined the battalion in 1999, Kwasnicki still felt unable to socialize because her colleague was younger and “at a different point in her life.”¹⁹⁷ Her testimony demonstrated how geography as well as age and gender affected Reservists’ ability to discuss peacekeeping tours and seek help if needed. Although Kwasnicki ostensibly escaped her peacekeeping tours without any serious health issues, many of her comrades were not so fortunate.

Captain Kelly Brett, a physician who saw firsthand the effects of trauma on returning soldiers, described how social and medical issues were intimately linked. The problem with immediately disbanding Reservists was that “there is some guy in rural Newfoundland who has been exposed to that [trauma] and no one around him understands what he was exposed to and he is just not the same guy he used to be and the civilian physician there that is trying to deal with him doesn’t have a clue what is wrong with this guy either.”¹⁹⁸ Soldiers who had only a few weeks prior been witness to horrific events or involved in firefights with belligerent forces suddenly found themselves transported back to their living room “with absolutely no support network.”¹⁹⁹ As a psychiatrist who had seen the fallout of Canada’s peacekeeping efforts, Greg Passey echoed Brett’s arguments about Reservists’ post-tour dispersal. Passey espoused that in the future “the whole issue about the reserves is something that needs to be addressed” because after being sent home without adequate time to be assessed and vent with colleagues, “they didn’t have the unit or the normal sort of comradeship that you would expect that would help

¹⁹⁶ Ibid., 13.

¹⁹⁷ Ibid., 12.

¹⁹⁸ Testimony of Captain Kelly Brett, 29.

¹⁹⁹ Testimony of CWO D.F. DesBarres, 10.

dissipate some of the PTSD stressors.”²⁰⁰ In most cases, Reservists were “sent off to nowhere, wherever that happened to be, often without a job or any employment and often without any sort of medical resources to help them deal with the situation.”²⁰¹ Master Warrant Officer Larabie echoed Passey’s appraisal, lamenting that “we came back, we handed our rifles in and we sent the reservists off on their merry way, never to be seen or heard from again ... and that ... in my mind, is criminal.”²⁰²

Anger and Disillusionment

Two of the most common feelings soldiers expressed during the Board of Inquiry were anger and disillusionment. The biggest target of their frustration was, unsurprisingly, the military itself. Throughout the Board’s proceedings, numerous soldiers testified they felt ignored or shunned by their battalion, regiment, and the Forces as a whole. For Lieutenant and Padre Michael Brown, the issue was one of responsibility. From his experiences as a peer and confidante to soldiers during the Medak aftermath, Brown knew many took “a lot of rage, disappointment, and loathing” back home.²⁰³ Brown himself also struggled with what he witnessed overseas, and told the Board that for months after returning from Croatia his wife said nighttimes were “like sleeping with a boxer.”²⁰⁴ Brown had numerous nightmares during which he crawled out of bed or rolled under it, often being unaware of his actions the next day when his wife informed him.²⁰⁵ He, like his peers, was angry that the CAF and DND seemed unwilling to shoulder their share of responsibility for soldiers’ health problems stemming from service:

“Responsibility is, if I ask you to go do something ... I accept the consequence that you may

²⁰⁰ Testimony of Lieutenant-Commander Greg Passey, 8.

²⁰¹ Ibid.

²⁰² Testimony of MWO Ed Larabie, 17.

²⁰³ Off, *The Ghosts of Medak Pocket*, 224.

²⁰⁴ Testimony of Lieutenant Brown, 56.

²⁰⁵ Ibid.

come back not the same as you left. I will own what I am responsible for. So that when you come back, I will hopefully be able to put you back together the way you were before you left. We do not do it.”²⁰⁶ Major Darrell Menard’s testimony also highlighted the theme of responsibility. He argued that, “when they [soldiers] are destroyed by doing a mission like that, I think the people that sent them there have a responsibility to take care of them.”²⁰⁷

Kelly Brett expressed anger at how the CAF and politicians seemed willing to send Canadian troops anywhere at any time, and without considering how many deployments they already shouldered. He angrily stated that once soldiers signed up “we somehow feel we have this right to expose them to whatever we feel like we can expose them to.”²⁰⁸ Brett felt it was “simply wrong” to send soldiers, in some cases, on eight or nine tours.²⁰⁹ The physical and mental weight of multiple tours caused many to collapse under the strain. Brett reported to the Board what the results were: “I do their release medicals in Calgary and it is the same story. [Soldiers said] I can’t take it. I just can’t go away again. There are huge family problems. There is alcoholism. There is drug abuse. There is all this stuff because guys aren’t given a break.”²¹⁰ Brett’s candid assessment reflected his belief that the number of operations and subsequent treatment soldiers received was, plainly put, “ruining people’s lives.”²¹¹ Captain Alain Guevremont, Padre and Croatia veteran, agreed with Brett, testifying that the situation was “burning our people, big time.”²¹² One particularly moving assessment came from Matt Stopford, himself a medically released soldier whose career was cut short by a litany of inexplicable physical and mental symptoms. He sorrowfully explained that, “When that faith is

²⁰⁶ Ibid., 60.

²⁰⁷ Testimony of Major Darrell Menard, 16.

²⁰⁸ Testimony of Captain Kelly Brett, 48.

²⁰⁹ Ibid.

²¹⁰ Ibid.

²¹¹ Ibid., 29.

²¹² Testimony of Captain Alain Guevremont, *Croatia Board of Inquiry*, September 23, 1999, vol. XII, 25.

broken by them [the CAF/DND], it's like somebody's torn your heart out and just tossed it away. That was my life. You guys talk about it as a career. That was my soul, my life. I love what I did. I still would love to do it."²¹³

Soldiers also directed their sorrow and frustration at the federal government and Canadian public. Civilian indifference led some CAF members to believe their country betrayed them. Major Dan Drew lamented that although Canadian troops had represented Canada "in the finest possible fashion" in the Balkans, many civilians did not know about their experiences.²¹⁴ Worse still, the Canadian government, more concerned about actual or potential scandals had "not acknowledged or even cared about their [soldiers'] sacrifices."²¹⁵ Retired Master Warrant Officer M.B. McCarthy, a Regimental Sergeant Major with 2PPCLI who served in Croatia in 1993, echoed Drew's appraisal. After noting citations Canadian peacekeepers received from the UN during the UNPROFOR Mission, and much earlier during the Korean War, when the regiment received the United States Presidential Unit Citation, McCarthy asked the Board: "And what has Canada given us? Absolutely nothing. Whether it is ... Canadian Forces, country, whatever, we have gotten nothing from the country."²¹⁶

Sergeant James Davis likewise vocalized frustration and disillusionment about how Canadian peacekeepers were treated upon their return. He recalled that while overseas soldiers sometimes received supportive letters from schoolchildren; letters that "were like gold" for troops bearing the brunt of Canada's foreign policy decisions.²¹⁷ Sadly, such kind actions inadvertently created a belief among troops that the Canadian public was deeply aware of current peacekeeping missions. Davis noticed a "huge gap" after he returned from Yugoslavia between

²¹³ John Wood, "Matt Stopford: Warrant Officer," in *The Chance of War*, 143.

²¹⁴ Testimony of Major Dan Drew, 27.

²¹⁵ Ibid.

²¹⁶ Testimony of CWO M.B. McCarthy (ret.), 20.

²¹⁷ John Wood, "Jim Davis: Sergeant," in *The Chance of War*, 50-51.

what he thought people knew and the actual reality.²¹⁸ He affirmed: “The Canadian public just doesn’t seem to know what’s going on in these places, what’s going on with this military.”²¹⁹ A lack of awareness and societal support caused Davis and other soldiers to question the reasons for their service. Davis candidly expressed his frustration at the public’s seeming indifference: “So am I dedicating my life to the Canadian public? At least the government has the decency to abuse you in the open. The Canadian public just doesn’t seem to care and that’s even harder to take.”²²⁰ Instead of worrying about what troops were doing overseas, he argued, Canadians were more concerned with “where we’re putting our investments and what’s the new plot on *Ally McBeal*.”²²¹ The trouble, Davis said, of being too caught up in day-to-day matters was that, “We forget that out there, in the real world, there are real Canadian troops who are doing a damn fine job for Canada. But no one seems to know that.”²²²

Andrew Godin further expounded on what Davis and a number of injured peacekeepers thought about public indifference. He argued that although Canadians were quite willing to honour fallen soldiers, the injured were forgotten:

Once a year ... we gather at cenotaphs all across the country to celebrate the fallen ... How many are actually injured? Probably about five times as many, but no thought is given to that. We honour the dead, because they made the ultimate sacrifice, but we don’t honour the injured. We don’t honour the people that are still alive and functioning. But we feel in our hearts and minds, ‘Yeah, I took a moment’ ... Well, sorry to say, that’s not quite enough.²²³

Sergeant Peter Vallée, a Croatia and Bosnia veteran from the Van Doos Regiment, believed the problem related to education; a point made evident by the fact that, “Some

²¹⁸ Ibid., 51.

²¹⁹ Ibid.

²²⁰ Ibid.

²²¹ Ibid.

²²² Ibid.

²²³ Godin interview.

Canadians don't know that Canada was even in Korea."²²⁴ He felt the situation could be vastly improved if education was provided about what the military "actually" did.²²⁵ Vallée affirmed that the public, when informed, was "very supportive" and interested, but simply put, "They don't know."²²⁶

There were, despite numerous veterans' assertions, ephemeral examples of public interest and support. Master Corporal Phil Tobicoe's Croatia Board testimony revealed the bolstering effect public showings of support had on returning peacekeepers. He described to the Board the welcoming atmosphere soldiers encountered after landing in Winnipeg: "I loved the greeting that the Winnipeg people gave us. My God there was – when we arrived in Winnipeg, we felt like something. There were ribbons on trees, signs, a hall greeted us, people. My God I didn't even know some of these families and they greeted us like they knew us. They sort of loved us and shook your hand. It was like the whole city came out for us."²²⁷ Regrettably, the moment was short lived. When Tobicoe and his comrades arrived in Calgary twenty-four hours later "there was nothing. There was a six foot table, a box of doughnuts and a coffee urn and there was only maybe one or two families there ... and the CO [Commanding Officer]."²²⁸

One of the strongest criticisms of the public and federal government came from Master Corporal Jordie Yeo, a Balkans veteran physically injured by shrapnel who, like numerous comrades, had many sleeps filled with nightmares after his return.²²⁹ Yeo invoked the United States' Vietnam experience in his evaluation of Canadian peacekeepers' predicament:

I can truly understand what soldiers from the United States who were in Vietnam have gone through. They came back and people hated them or just ignored them. That's

²²⁴ John Wood, "Peter Vallée: Sergeant," in *The Chance of War*, 213.

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Testimony of Master Corporal Phil Tobicoe, 15.

²²⁸ Ibid.

²²⁹ John Wood, "Jordie Yeo: Master Corporal," in *The Chance of War*, 226, 230.

what happened to a lot of Canadian soldiers. Just about every single guy that's in the Canadian Armed Forces has done some sort of tour of duty in Yugoslavia, Haiti, Rwanda, Somalia and we're doing this because the Canadian people and our politicians believe that it's the right thing. If it's the right thing, then how come when we come back home nobody says, 'Good job'? I would really like somebody to sit down and explain to me why.²³⁰

Reminding Canadians, "It's your country and your soldiers are your people," Yeo challenged citizens unhappy with overseas operations to discuss the matter with politicians.²³¹ In Yeo's mind, the only worse thing than criticism was indifference. He exhorted Canadians to take action: "Stop sitting on your hands eating your Pringles."²³²

New Millennium, New Dawn?

Yeo's invocation of Vietnam demonstrated the historical links between traumatized Canadian peacekeeping veterans' experiences and soldiers' treatment after earlier conflicts. What made the Canadian experience unique, though, was that unlike in Britain and the United States, the CAF's first large-scale encounter with PTSD and "combat" stress in the late twentieth century came not from war but ostensibly innocuous peacekeeping operations. As the Board of Inquiry came to a close and issued its final report in January 2000, it was clear that several traditional notions were under siege. First, while never discounting the possibility of toxic exposure, after scientific tests and expert testimony the Board concluded that the predominant factor in Canadian soldiers' illnesses was the overwhelming psychological stress they endured.²³³ The Board, the CAF, and the Canadian public learned – or more accurately put, relearned – as Canadians had during the First and Second World Wars, that every combatant, or in this case

²³⁰ Ibid., 231.

²³¹ Ibid., 232.

²³² Ibid.

²³³ Sharpe, *Croatia Board of Inquiry*, passim.

peacekeeper, had a breaking point. Moreover, they learned that soldiers debilitated by traumatic events or plagued with recurring nightmares were not lesser men, but simply traumatized by witnessing horrific scenes and living in conditions that, for all intents and purposes, resembled a war zone.²³⁴ Nevertheless, as the many testimonies highlighted, a CAF culture dominated by ideals of heightened masculinity and traditional views of the stoic soldier ensured that those suffering from psychological problems kept it to themselves, for fear of social ostracism, and equally important, to prevent an early release from the Forces.

Although the Canadian experience was unique in a few key respects, there was one important link between 1990s peacekeepers and soldiers in earlier conflicts. As with the First and Second World Wars, and most prominently the Vietnam War, there was an intangible but nevertheless important connection between the level of medical and social support troops received upon their return home, and their ability to rationalize and overcome operational experiences. Chairman Sharpe and the Board concluded, unsurprisingly given the numerous testimonies expressing fear, anger, disillusionment, and sorrow, that the low level of public awareness and departmental prevarications “contributed to the problems suffered by returning soldiers.”²³⁵ Worse still, a significant number of CAF members – especially Reservists – were dispersed almost immediately after their return, leaving them unable to normalize their experiences and seek informal comfort from comrades. As with Corporal Prodaniuk’s story indicated at the beginning of this chapter, the “social conditions of the battalion” had a salutary effect on both the social life and mental health of troops.²³⁶ Without that support, some already suffering with psychological difficulties collapsed under the strain. There were a number of previous methods for bringing soldiers home, but Master Warrant Officer Ed Larabie, trained in

²³⁴ Ibid., 3.

²³⁵ Ibid., 4.

²³⁶ Prodaniuk interview.

CISD, cited the First and Second World War methods as a potential solution. He mused that “maybe they had the right idea during the [World] wars, you put them on a nice slow boat, a chance to [informally] debrief each other on the way home.”²³⁷ Whatever the solution, it was evident to the Board that the quick disbanding of units after peacekeeping operations contributed, however difficult to measure, to an already stressful reintegration.

Canadian UNPROFOR troops, at the worst forced to clean up the aftermath of ethnic cleansing, and at best living under constant threat of enemy action, also returned to find their mission unknown among civilians and unacknowledged by the governments that sent them. Consequently, many men and women in uniform suffered in silence, another point made abundantly clear by the anecdotal evidence provided during the BOI. About 300 soldiers who served in Croatia from 1993 to 1995 reported illness from service, but the Board inferred that “many more” were staying in the shadows.²³⁸ Innumerable troops, like Prodaniuk, soldiered on, only to later succumb to the “failed processing” of their experiences and traumatic memories.²³⁹ Although it was impossible to put a figure on the number of soldiers psychologically affected who did not come forward, if Kelly Brett and Greg Passey’s testimonies were any indication, that number was likely in the thousands.²⁴⁰

As the new millennium approached, the Croatia Board of Inquiry’s conclusions cast a light on sweeping changes needed within the CAF. The Board’s enlarged mandate – from investigating toxic exposure to overall treatment of injured soldiers – displayed the “frustrations and humiliating treatment experienced by injured soldiers,” many of whom served on multiple

²³⁷ Testimony of Master Warrant Officer Ed Larabie, 15; Unfortunately, the salutary effect of taking the “slow boat” home, while seemingly proven right during the First and Second World Wars, nevertheless did not seem to decrease the number of UK troops suffering from PTSD after the Balkans War.

²³⁸ *The Globe and Mail*, 17 December 1999.

²³⁹ See Prodaniuk’s thoughts at the beginning of this chapter.

²⁴⁰ Brett himself said as much in his testimony. He stated that he conducted numerous appointments for soldiers from Yugoslavia: “in the high thousands, if not into the tens of thousands.” See testimony of Captain Kelly Brett, 30.

tours with only twelve months at home between deployments.²⁴¹ Chairman Sharpe, critical throughout the Inquiry of how the CAF and VAC handled injured soldiers, declared to the Canadian media that, “We don’t take as good care of our soldiers as our airplanes.”²⁴² Sharpe and Mike Spellen also noted the difficulties that a historically persistent and unwavering macho culture caused for injured soldiers, and especially the psychologically injured, who were encouraged to stoically bear pain and suffering.²⁴³ At a news conference Sharpe plainly stated the issue: “The macho image is [still] a major problem for our people.”²⁴⁴ Contrary to what predominant CAF cultural beliefs argued about PTSD and other psychological illnesses, BOI testimonies proved to Sharpe and the Board that most soldiers reporting problems were not “whinging and whining” malingerers, but genuinely injured troops who deserved the benefit of any doubts.²⁴⁵ Unfortunately, the Board exposed a recurring theme in Canadian military and medical history – the burden of proof still lay with injured soldiers and veterans to prove their illness was service-related. Sharpe affirmed that the primary way to tackle that problem was to “focus on the patient, not the illness.”²⁴⁶ In January 2000, it remained to be seen whether or not CAF and DND leaders would heed that advice.

²⁴¹ *The Globe and Mail*, 17 December 1999.

²⁴² *Ibid.*

²⁴³ *Ibid.*

²⁴⁴ *Ibid.*

²⁴⁵ *The Globe and Mail*, 29 October 1999.

²⁴⁶ Sharpe, *Croatia Board of Inquiry*, 30.

CHAPTER 6: NEW MILLENNIUM, NEW REFORMS, OLD PROBLEMS

The soldier is alone in his war with terror and we have to recognize the first signs of defeat that we may come in time to his rescue.¹

During the early morning of 15 March 2001, thirty-one-year-old Corporal Christian McEachern, a 1PPCLI member, drove his sport utility vehicle through the doors of Garrison Headquarters at Canadian Forces Base Edmonton.² He subsequently drove in circles through empty personnel offices, knocking over desks and causing significant property damage.³ McEachern was discovered, still behind the wheel, weeping and incoherent. After his arrest he assaulted a member of the Military Police.⁴ For his actions, the Crown laid five charges against him, including impaired driving, mischief, and assaulting a peace officer.⁵ He was released from the military in July 2001.

Like numerous colleagues, McEachern participated in difficult peacekeeping operations during the early to mid-1990s, including missions in Croatia and Uganda. In the former country, he was deeply affected after a fellow soldier died in a land-mine explosion.⁶ Later, in Uganda, operational restrictions forced him to helplessly watch as a woman was raped outside a military compound.⁷ Adding to his trauma, McEachern saw a man beaten to death and was once again forced to stand by as the man's disfigured body was dragged away.⁸ By 1997, McEachern struggled heavily with what he witnessed overseas, and in September 1997 psychiatrist Lieutenant-Commander Greg Passey diagnosed him with PTSD.⁹ For the next two-and-a-half

¹ Lord Moran, *The Anatomy of Courage*, xxi.

² *The National Post* (Toronto), 15 November 2002.

³ Ibid.

⁴ Ibid., 4 April 2001.

⁵ *The National Post*, 15 November 2002, 4 April 2001.

⁶ Ibid., 15 November 2002.

⁷ *The Globe and Mail*, 6 February 2002.

⁸ Ibid.

⁹ *The National Post*, 15 November 2002.

years he was on sick leave and under Passey's care until Passey resigned from his twenty-two-year career in the Forces in September 2000, due to what he saw as Ottawa's mishandling of soldiers' mental illness.¹⁰ McEachern's weekly appointments were cut down to one every three months after Passey's retirement, and, in combination with a lack of social support, contributed to his unraveling.¹¹ Just a day before he drove his vehicle into Garrison Headquarters, McEachern privately received a medal for his peacekeeping efforts in Africa.¹² His defence counsel later argued that the belated medal was bittersweet, since he was on sick leave for two years and felt ostracized from his unit.¹³

McEachern's mother, Paula Richmond, travelled to Ottawa shortly after the incident in April 2001 to plead for help from the Parliamentary Standing Committee on National Defence and Veterans Affairs, but a Liberal committee member prevaricated and refused to hear her grievances, claiming he was unprepared.¹⁴ Undeterred, Richmond wrote a letter to the *National Post*, which subsequently published excerpts and highlighted McEachern's case, as well as Richmond's claims that the Chrétien government was not doing enough to alleviate a PTSD "crisis" in the Canadian Forces.¹⁵ She then, along with her local MP Leon Benoit, approached the office of CAF/DND Ombudsman André Marin. After meeting with Richmond and Corporal McEachern in Edmonton on 4 April 2001, Marin agreed to investigate McEachern's claim that soldiers with PTSD were treated unfairly by the military.¹⁶

¹⁰ Ibid; Passey approached the *National Post* shortly after McEachern's actions in March, hoping to raise awareness of the issue and highlight what he viewed as Ottawa's indifference to the PTSD problem. See *ibid*, 30 March 2001.

¹¹ André Marin, *Report to the Minister of National Defence*, 21.

¹² *The National Post*, 4 February 2003.

¹³ Ibid.

¹⁴ *The National Post*, 3 April 2001.

¹⁵ Ibid.

¹⁶ Marin, *Report to the Minister of National Defence*, v; *The National Post*, 11 April 2001; Thanks and acknowledgements to former Director of the Special Ombudsman Response Team and Lead Investigator Gareth Jones, and Mr. Sharpe, for clarifications about the McEachern case.

McEachern's story was recounted on television news broadcasts and in national newspapers. His trial and Marin's 2002 report on the systemic treatment of soldiers with PTSD, the latter published as a result of McEachern's complaint and numerous similar claims, once again drew attention to the plight of soldiers psychologically affected by military service. McEachern's case divided military members and, like the Croatia Board of Inquiry, framed discussions throughout the first decade of the new millennium. McEachern's trial, covered by the *Globe and Mail* and *National Post*, hinged on whether his actions were deemed voluntary or an involuntary result of his illness. The defence's case pitted Greg Passey's clinical experience and research on PTSD amongst Canadian peacekeepers against Randy Boddam, chief of psychiatry and mental health for the CAF.¹⁷ Boddam testified that McEachern was "distraught, suicidal and intoxicated" during the morning of 15 March 2001, and undertook his destructive actions willingly and voluntarily.¹⁸ In a later 2008 article for *Criminal Law Quarterly*, Benjamin Kormos examined the case and disapproved of the fact that Boddam testified despite admitting during cross-examination that he "had not reviewed any of McEachern's personnel or medical files" and in Kormos' opinion "had a tremendously limited foundation upon which to base any professional opinion."¹⁹ For his part, Passey testified that McEachern was in a "robotic" state of dissociation, a phenomenon he witnessed on several occasions during their weekly appointments.²⁰ McEachern testified that he remembered little of that night except vague memories of drinking scotch and later seeing a woman looking down at him behind the wheel of his vehicle.²¹ Passey also used the trial as a forum to raise awareness of what he judged to be systemic problems

¹⁷ *The National Post*, 11 December 2002.

¹⁸ *Ibid*; Boddam also implied in his testimony that McEachern drove into Garrison Headquarters to take \$3000 in accumulated leave pay that he had been denied earlier that day. Boddam stated that, "He [McEachern] was driving that evening to the place that would be the source of that money." See *The National Post*, 11 December 2002.

¹⁹ Benjamin Kormos, "The Posttraumatic Stress Defence in Canada: Reconnoitering the Old Lie," *Criminal Law Quarterly* 54, no. 2 (2008): 222.

²⁰ *The Globe and Mail*, 16 November 2002; *The National Post*, 11 December 2002.

²¹ *The National Post*, 15 November 2002.

within the CAF. He testified that senior officers and DND officials knew PTSD was an increasing problem throughout the 1990s and early 2000s but did little to alleviate it, citing overwork and frustration at their indifference as the primary reasons for his retirement.²²

Much of Passey's testimony during McEachern's trial echoed his October 1999 testimony at the Croatia Board of Inquiry. He affirmed that CAF and DND leaders in Ottawa kept resources and information centralized in the capital, rather than encouraging an open dialogue and providing adequate services at bases nationwide. He likened the CAF's handling of PTSD to "having a fire brigade in Ottawa and, if you have a forest fire [in the form of suffering of soldiers], trying to bring all the trees to Ottawa to put them out."²³ Ultimately, Madame Justice Doreen Sulyma sided with the CAF's take on events, rejecting McEachern's PTSD as a defence for his actions.²⁴ On 3 February 2003 she ruled that "His actions were voluntary."²⁵ The Crown sought six to nine months in jail, but Sulyma opted instead for a fourteen-month conditional sentence.²⁶ McEachern calmly hung his head when the verdict was read.²⁷ While still in the court room his mother sobbed and declared, "It's his whole life they [the CAF] took from him."²⁸

Although McEachern was found guilty at the Court of Queen's Bench, a different form of vindication nonetheless came a year earlier in the guise of Marin's February 2002 Ombudsman's Report. Marin's investigative team, headed by Lead Investigator Gareth Jones, and with advisory assistance from former Croatia Board Chairman Joe Sharpe, interviewed approximately 200

²² Ibid; At the trial, Passey noted, as he had during the Croatia BOI, that the number of psychiatrists in the Canadian Armed Forces had been cut in half from eleven to six, at the same time as he was warning military leaders about an increasing number of peacekeepers returning with psychological problems. See *The National Post*, 30 March 2001.

²³ Ibid.

²⁴ *The Globe and Mail*, 8 February 2003.

²⁵ *The National Post*, 4 February 2003.

²⁶ *The Globe and Mail*, 8 February 2003; *The National Post*, 4 February 2003.

²⁷ *The National Post*, 4 February 2003.

²⁸ Ibid.

soldiers, of whom about half had been diagnosed with PTSD.²⁹ The team discovered a culture that by and large, even after the events of the past decade and the Croatia Board's January 2000 conclusions, still refused to countenance the existence and prevalence of mental difficulties among Canadian soldiers. Marin's team found "overwhelming evidence that many within the CF are sceptical about whether PTSD is a legitimate illness" and a "distressingly common belief among both peers and leaders that those diagnosed with PTSD were 'fakers,' 'malingerers,' or simply 'poor soldiers.'" That belief persisted despite evidence from medical professionals and caregivers that instances of soldiers exaggerating or faking PTSD symptoms were rare — somewhere around 1 to 3%.³⁰

Marin's report contained aspects that were, according to one newspaper columnist, "blatantly self-serving and self-congratulating," but his team nevertheless provided a vast array of evidence demonstrating that the CAF was still split between those who deemed PTSD a legitimate illness and an "old guard" who argued otherwise.³¹ The Report also demonstrated that several past issues, such as stigma, lack of social support, problems with bureaucracy, and soldiers' career concerns, were still a problem in the new millennium, and that any attitudinal changes would be slow to come. Marin concluded that McEachern's complaints were justified and CAF problems were systemic in nature. His Report stated: "As is the case for many CF members who suffer from PTSD, he was stigmatized and isolated from his unit, without the support from his peers that could have sustained him."³² Unbeknownst to McEachern at the time

²⁹ Marin, *Report to the Minister of National Defence*, v; Marin's team interviewed numerous people within and outside the military for its report, including: PTSD sufferers' families; members of McEachern's chain of command; senior personnel at NDHQ; staff members at three Operational Trauma and Stress Centres; members of the International Red Cross; and foreign military members. They also consulted Roméo Dallaire and Chief of the Defence Staff Maurice Baril. See *ibid.*

³⁰ *Ibid.*, vi.

³¹ Quotation from a *Toronto Star* article on the subject by longtime *Star* columnist Rosie DiManno. See *The Toronto Star*, 21 June 2002.

³² Marin, *Report to the Minister of National Defence*, ix.

was that his case would become a catalyst for change within the CAF. With the McEachern case receiving national media coverage, and Marin's Ombudsman's report confirming the findings of earlier inquiries, Defence Minister Art Eggleton vowed in February 2002 to eliminate the stigma surrounding PTSD and mental health discussions.³³ With Canada then engaged in a new war in Afghanistan and the number of PTSD sufferers expected to climb, it remained to be seen whether Eggleton's promise could be implemented.

The Call to Arms

The events of 11 September 2001 were, according to political scientist Patrick James, "a huge domino, with others toppling over after it."³⁴ With Canadian troops already deployed in numerous peacekeeping missions around the world, the call nonetheless came for the CAF to participate in a US-led war effort in Afghanistan. Although the military was tightly stretched, Canadian military leaders dutifully sent a battalion of soldiers in January 2002, preceded a month earlier by elite commandos of Joint Task Force 2.³⁵ Ultimately over 40,000 CAF members served in Afghanistan between 2001 and March 2014, when the final army and police trainers returned to Canada. It was the largest Canadian military operation since the Second World War.³⁶ In addition to enduring summer temperatures reaching as high as 50 degrees Celsius, and a constant sense of danger from both the environment and populace, Canadian troops also participated in extensive combat, including Operation Medusa, a 2006 Canadian-led offensive in

³³ *The Globe and Mail*, 6 February 2002.

³⁴ Patrick James, *Canada and Conflict*, 85.

³⁵ In a testament to how stretched CAF resources were, Granatstein noted that when soldiers arrived, they had woodland uniforms on instead of a more appropriate desert-style of dress. Canadian soldiers also had to be transported by air and ground vehicles borrowed from the United States. See Granatstein, *Who Killed the Canadian Military?*, 6.

³⁶ Veterans Affairs Canada, "The Canadian Armed Forces in Afghanistan." Government of Canada. <http://www.veterans.gc.ca/eng/remembrance/history/canadian-armed-forces/afghanistan> (accessed January 13, 2015). This level of commitment made the Afghanistan War the largest military operation since the Second World War.

Kandahar province that was the nation's largest offensive operation since Korea.³⁷ The Afghanistan War's character, a difficult mixture of combat and stabilization efforts, metaphorically symbolized Canadians' ambivalence about the nation's appropriate role in both the conflict and international affairs.

In his 2010 book on Operation Medusa, retired Colonel and military historian Bernd Horn argued that with Medusa, Canada "finally put to rest the peacekeeping myth that it had acquired in national and international psyches since the 1950s and once again overtly proved itself as a warfighting [sic] nation within the international defence community."³⁸ Canadian troops certainly once again proved the nation's military prowess, but Canadians' attachment to a peacekeeping identity remained, even if tempered by Afghanistan. Although Canadian civilians broadly supported the Afghanistan War, as recently as 2012 an EKOS survey reported that 63% of civilians still identified peacekeeping as the CAF's primary role on the world stage.³⁹ In their 2013 essay on public opinion and soldier identity, Stéphanie Bélanger and Michelle Moore argued such surveys indicated that even after Afghanistan, Canadian civilians still wished "to be perceived as peacekeepers."⁴⁰ Canadians were agreeable about the use of force in Afghanistan to fight a "war on terror," but an ingrained sense of peacekeeping as the nation's *raison d'être* in international politics was reflected in intense reactions to every Canadian fatality.⁴¹ There was particular outrage nationwide in April 2002 when a US Air Force fighter pilot mistakenly

³⁷ Ibid; Operation Medusa was also NATO's first battle since its creation over fifty years earlier. See Bernd Horn, *No Lack of Courage: Operation Medusa, Afghanistan* (Toronto: Dundurn Press, 2010), 13; Medusa cost the Canadians five dead and forty wounded within the first forty-eight hours, a tough casualty toll unseen in decades.

³⁸ Horn, *No Lack of Courage*, 14.

³⁹ Stéphanie Bélanger and Michelle Moore, "Public Opinion and Soldier Identity: Tensions and Resolutions," in Aiken and Bélanger, 104.

⁴⁰ Ibid., 103-104.

⁴¹ James, *Canada and Conflict*, 35, 53; As James noted, Canadian fatal casualties, which totaled 157 by the end of combat operations in 2011, were a small fraction of losses endured in single battles in the First and Second World Wars. Nonetheless, after many decades of peacekeeping, during which fatalities were few and far between (and usually caused by accidents), Canadians had become highly sensitized to even a single death.

bombed Canadians participating in a live-fire exercise, killing four soldiers from the Princess Patricia's Canadian Light Infantry.⁴² War casualties "signalled activity that many had assumed to be a thing of the past."⁴³

The Afghanistan conflict brought home the realization that the military was participating in something inherently different from peacekeeping operations; something which by its very nature involved inflicting and sustaining casualties. Canadians were supportive, but cautious and watchful of what a shifting role in international affairs entailed.⁴⁴ Unlike previous operations during the 1990s, *all* aspects of the Afghanistan War were intensely scrutinized by politicians, the media, and Canadian public.⁴⁵ The conflict was in many ways a "national preoccupation" throughout the first decade of the new millennium and at the centre of debates over Canada's role in world events after 11 September 2001.⁴⁶ As part of that preoccupation, heated discussions surrounded the effect Afghanistan service, and CAF operations as a whole, had on not just the bodies, but also the minds of Canadian troops.

Responses to PTSD and Mental Health

In the late 1990s and early in the new millennium, CAF and DND leaders responded to concerns about PTSD and systemic treatment of mentally affected soldiers in numerous ways. Given the media coverage the subject received in the late 1990s, the CAF, DND, and politicians realized tangible actions were necessary to demonstrate something was being done to combat the problem. In November 1998 the first definitive step came with the announcement of five Operational Trauma and Stress Support Centres (OTSSCs) at CFBs Halifax, Esquimalt,

⁴² Granatstein, *Who Killed the Canadian Military?*, 171; *The Globe and Mail*, 19 April 2002.

⁴³ James, *Canada and Conflict*, 35.

⁴⁴ *Ibid.*

⁴⁵ Part of this was the result of the Digital Age, which allowed greater spread of information and a decreased ability to prevent such information from reaching the public.

⁴⁶ James, *Canada and Conflict*, 2.

Valcartier, Edmonton, and CAF Headquarters in Ottawa.⁴⁷ Implemented in late 1999, each OTSSC consisted of a military psychiatrist, a military mental health nurse, a military social worker, CAF chaplain, and one or more civilian psychologists.⁴⁸ OTSSCs provided CAF members suffering from service-related psychological difficulties with diagnostic assessments, individual treatment (psychotherapy and/or pharmacotherapy), group treatment, and family therapy.⁴⁹ They also provided outreach programs, helping to educate military and civilian healthcare workers about the unique aspects of psychological problems caused by military service.⁵⁰

Aside from the benefits for CAF members and their families, OTSSCs also helped decrease the CAF's reliance on a "very limited number" of civilian psychologists and psychiatrists with experience treating soldiers.⁵¹ That reliance was, as discussed during the Croatia BOI, a particular problem throughout the mid- to late-1990s, since soldiers were uncomfortable discussing psychological problems with civilian practitioners unfamiliar with military life and its challenges. But while the OTSSCs helped to treat mentally injured soldiers, they also revealed the intricacies of dealing with old stigmas. The location of OTSSCs – on- or off-base – became a particularly controversial subject, even amongst those dedicated to aggressively attacking mental illness. In his December 2002 follow-up to the McEachern report, André Marin criticized the CAF's decision to place all OTSSCs on-base, arguing that locating them on-base made psychologically injured soldiers reluctant to come forward.⁵² Previously,

⁴⁷ Brock and Passey, "The Canadian Military and Veteran Experience," 92; Two more OTSSCs were opened at CFBs Petawawa and Gagetown in 2011.

⁴⁸ Ibid.

⁴⁹ National Defence and the Canadian Armed Forces, "Canadian Armed Forces Mental Health Services." <http://www.forces.gc.ca/en/caf-community-health-services-mental/index.page#otssc> (accessed January 14 2015).

⁵⁰ Ibid.

⁵¹ Brock and Passey, "The Canadian Military and Veteran Experience," 92.

⁵² André Marin, Ombudsman National Defence and Canadian Forces, *Follow-Up Report: Review of DND/CF Actions on Operational Stress Injuries* (Ottawa: Department of National Defence, 2002), 21.

Marin's February 2002 report recommended a pilot project involving the establishment of one OTSSC in "more anonymous premises off-base."⁵³ His rationale was simple. Marin cited an example where an OTSSC was located on the second floor of a base hospital – soldiers colloquially termed the stairway leading up to the Centre the "stairway of shame."⁵⁴

Canadian Forces leaders working to combat stigma saw the OTSSC location issue in a different light. Major Stéphane Grenier, the lead on the 1998 video about Rwanda peacekeeping trauma, disagreed with Marin's assessment. He believed that locating OTSSCs off-base was "short sighted" and helped maintain current stigmas.⁵⁵ While increasing access to care and potentially encouraging more soldiers to seek treatment in the short term, Grenier nonetheless argued that off-base OTSSCs would cost significant tax-payer money and imply to CAF members that psychologically injured soldiers needed treatment away from their posted base, "like people who have the plague."⁵⁶ The CAF unsurprisingly approached the fight against stigma from a strategic perspective, and CAF leaders kept all OTSSCs on-base despite Marin and future Ombudsmen's protestations.

Regardless of their intended purpose, OTSSCs and any related initiatives to combat mental health challenges were only effective if injured soldiers *actually* utilized them – that meant attacking stigma head on. Thus, the military also took steps to address the inherent challenges of penetrating a culture that shunned discussions of mental "disorder." Grenier, a UN spokesperson in Rwanda from 1994-1995 and Afghanistan veteran, was himself deeply affected by his military experiences and subsequently diagnosed with PTSD. After the aforementioned 1998 Rwanda video was unveiled, Major-General Christian Couture approached Grenier and

⁵³ Marin, *Report to the Minister of National Defence*, 201-202.

⁵⁴ *Ibid.*, 71.

⁵⁵ Stéphane Grenier, e-mail message to author, July 22, 2015.

⁵⁶ *Ibid.*

expressed interest in the subject, asking him to delve into possible solutions and report back.⁵⁷ Couture subsequently had Grenier posted to the Director, Casualty Support and Administration so he could work full-time on his initiatives.⁵⁸ Under the Director, Lieutenant-Colonel Dave Wrather, a “very empowering boss” with the attitude of “do what’s right and later find the policy to support the action,” Grenier was given latitude to explore novel ways of approaching stigma.⁵⁹ Based on his own treatments, which he deemed somewhat “antiquated” and inconsistently effective, Grenier became “quite obsessed” with examining how the military as an institution approached the issue from leadership and clinical perspectives.⁶⁰ He explained:

I refused to embrace the notion that I had an illness ... or an ailment called ‘post traumatic stress disorder’ ... [W]hen you’re first hit with this whole notion that your brain is sick, that in itself is a huge barrier to recovery; when you learn that you have a ‘disorder.’ So as a patient, as a human being, as a soldier, I started thinking, ‘What the frick is wrong with us?’ ... and over the years developed a concept where ... what was needed was to de-medicalize these issues to a certain degree. Not that treatment needs to be de-medicalized, but the way our culture, our organization, our leaders, our employees, our soldiers perceive these conditions, has to be terminology that is accepted culturally by our people.⁶¹

Similar to Roméo Dallaire and Joe Sharpe, Grenier believed one solution was to convince both the chain of command and rank-and-file soldiers that psychological injuries were as legitimate as physical ones. For Grenier, this strategy involved relabeling medical words that were anathema to soldiers and military culture. He argued that “it’s one thing to blame stigma, but it’s another thing to actually strategically address the issue of stigma by rebranding to a

⁵⁷ Grenier interview; Couture was at that time a two-star general and was at the video unveiling filling in for Dallaire, who was feeling unwell and unable to attend the event. Couture was later promoted to Lieutenant-General. He also in 1999 assisted in the creation of the DND/VAC Centre for the Support of Injured and Retired Members and their Families. See Veterans Affairs Canada, “Christian Couture.” <http://www.veterans.gc.ca/eng/about-us/departement-officials/minister/commendation/bio/157> (accessed January 23, 2015).

⁵⁸ Now called Director Casualty Support Management.

⁵⁹ Grenier, e-mail message to author, July 23, 2015.

⁶⁰ Ibid.

⁶¹ Ibid.

certain degree, at one level anyway, many things that happen [e.g. psychological injuries].”⁶² From 1998 to 2001 he pondered and researched the problem.⁶³ During his investigation he was particularly intrigued by Queen’s University professor and retired RCAF air navigator Allan English’s 1999 paper for the Croatia Board on historical and contemporary interpretations of combat stress.⁶⁴ Reading the word “injury” while pondering stress’ effect on past soldiers gave Grenier the idea for a new term for service-related stress illness – “Operational Stress Injury (OSI).”⁶⁵ Utilizing the term “operational stress” was a conscious decision to encompass “wider meanings” than narrow medical diagnoses.⁶⁶ It was also demonstrative of how, like “battle exhaustion” was used in the Second World War to lessen the stigma of diagnostic labels such as “neurosis” or “psychoneurosis,” “operational stress injury” was likewise a military solution to a military medical problem.⁶⁷

The new OSI term encompassed a wide range of psychological injuries stemming from military service, including PTSD, other anxiety disorders, depression, and conditions less severe but still impediments to daily functioning.⁶⁸ Bringing those various maladies under one umbrella, with an emphasis on “injury,” was an attempt to reduce the stigma of psychiatric diagnoses and demonstrate that like a broken leg, the psychological and physiological symptoms of PTSD “resulted from injuries to the brain and psyche, caused by exposure to military-related trauma.”⁶⁹ Grenier and like-minded reformers wished to place unseen psychological injuries on the same

⁶² Ibid.

⁶³ Grenier interview.

⁶⁴ See English, “Historical and Contemporary Interpretations of Combat Stress Reaction,” cited earlier.

⁶⁵ Grenier interview.

⁶⁶ Richardson et al. “Operational Stress Injury Social Support,” 62.

⁶⁷ Ibid.

⁶⁸ Brock and Passey, “The Canadian Military and Veteran Experience,” 93; The definition of OSI was taken from the VAC website. See Veterans Affairs Canada, “Understanding Mental Health.” <http://www.veterans.gc.ca/eng/services/health/mental-health/understanding-mental-health> (accessed January 21, 2015).

⁶⁹ Brock and Passey, “The Canadian Military and Veteran Experience,” 93.

plane as visible, physical ones.⁷⁰ In his own words, Grenier said his intent was “not to transform the way clinicians diagnose PTSD, but it was to allow our [military] culture to understand that if you go to war, or if you go on an operation somewhere, some people might get physically hurt, but those who are mentally hurt are equally as injured as others.”⁷¹ He was trying to achieve “a [physical] parallel for mental health whereby people can talk about Bob now from a mental health perspective outside the clinical terminology. They don’t have to say ‘Bob has post-traumatic stress disorder,’ which has a hugely negative connotation in the minds of that [military] culture. They can simply say ‘Bob had a real tough tour, Bob had a real tough operation, he’s not been the same; he might be injured.’”⁷²

Simultaneously Grenier worked to effect change where the rubber met the road. From 1998 to 2001 he developed a support program for psychologically injured soldiers. In March 2001 while posted at Land Force Central Headquarters in Toronto, Grenier learned about the McEachern case and asked his commanding officer, Major-General Walter Holmes, for permission to fly to Edmonton and meet with the young corporal.⁷³ Holmes, supportive of Grenier’s work, gave his blessing. Grenier promptly booked a flight and met with McEachern, who was awaiting trial at the Alberta Hospital, a psychiatric hospital in northeastern Edmonton. Their meeting convinced Grenier decisive changes were necessary. He recalled:

I go to the Alberta Hospital ... sign him out for the day, to find out that nobody [from the CAF] had visited him. He was there after doing a bit of time in jail ... We spent the whole day together, hit it off, and that’s when it came to me, ‘Holy fuck, things have to change.’ Because, you know, I had always asked myself through my own isolation and struggles ... ‘I’m a captain, I’m a major; if it’s tough for me imagine what it must be like for the corporal’ ... I have the latitude to take walks, to walk away, to go to meetings, to

⁷⁰ Ibid.

⁷¹ Grenier interview.

⁷² Ibid.

⁷³ Ibid.

go for coffee, but a corporal doesn't have all that latitude. So that was a huge precipitating moment.

After seeing McEachern, Grenier decided to meet with fellow veterans from the Rwanda mission during a business trip to Ottawa. There he brought a few colleagues to lunch to hear their opinions about his idea for a peer-support-based program for psychologically affected troops.⁷⁴ They were enthusiastic about the idea and provided him with further input. Thus, Grenier became in his own words a “glue stick” for various ideas stemming from his research, the McEachern case, and ideas from rank-and-file soldiers.⁷⁵

In May 2001, Grenier's efforts came to fruition with the creation of the Operational Stress Injury Social Support program (OSISS).⁷⁶ OSISS became operational in March 2002, and combined the timeless belief that soldiers know best other soldiers' plight with a formal structure under the aegis of the DND and Veterans Affairs. The first major step involved hiring Peer Support Coordinators (PSCs), men or women diagnosed with an OSI but deemed by their psychologist or psychiatrist to be at a sufficient stage of recovery to handle support work.⁷⁷ Each PSC was required to attend mandatory training provided by a multidisciplinary team of psychiatrists, psychologists, clinical nursing specialists, and social workers at St. Anne's Hospital in Montreal.⁷⁸ Training activities included learning about peer support, methods of conflict resolution, how to understand and respect boundaries, and ensuring continued self care.⁷⁹

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ Brock and Passey, “The Canadian Military and Veteran Experience,” 93.

⁷⁷ Ibid; As the program expanded OSISS later created Family Peer Support Coordinators, men or women whose family member served in the CAF and who were affected by their family member's OSI.

⁷⁸ Richardson et al. “Operational Stress Injury Social Support,” 59.

⁷⁹ Ibid.

Once hired and trained, PSCs were involved in a consistent dialogue with clinicians and provided continuing education.⁸⁰

As the program expanded nationwide PSCs' tasks included providing outreach and one-on-one assistance for OSIs sufferers, organizing peer-based social support groups, mentoring those in recovery, and organizing volunteer programs.⁸¹ For coordinators like peacekeeping veteran Greg Prodaniuk, one of the first PSCs hired when OSISS launched in 2001, more than a vocation, support work provided an outlet for helping others who were suffering. Prodaniuk stated: "I think the compassion and care that I got from those around me when I was not doing well is really the thing that I sort of in a way got addicted to. And that's the piece I think that has been a profound change in my life."⁸² Prodaniuk's goal, like the entire organization, was to help others have a profound change as well. OSISS was highly praised by the Ombudsman in his December 2002 follow-up report to the McEachern complaint. Marin noted that his investigators heard "widespread praise for OSISS throughout the CF community and VAC."⁸³ He argued that OSISS would be a "key contributor to the cultural change required to combat the stigma associated with OSIs and to ensure that CF members who may have an OSI are not too frightened to come forward to get the help they need as soon as possible."⁸⁴ Grenier, Couture, and Wrather were all singled out for their efforts, as well as the "commitment and dedication of the OSISS peer co-ordinators."⁸⁵

Despite the widespread praise OSISS received, resistance to the OSI term and OSISS program nonetheless developed from within the civilian and military medical communities. The "most frequent" complaints came from professionals who saw the Operational Stress Injury term

⁸⁰ Ibid., 60.

⁸¹ Prodaniuk interview.

⁸² Ibid.

⁸³ Marin, *Follow-Up Report*, 79.

⁸⁴ Ibid., 81.

⁸⁵ Ibid.

as “imprecise and not reflecting the current terminology their professions use to designate those possessing the symptoms of OSI [i.e. Using “OSI” instead of “PTSD” etc.].”⁸⁶ Grenier attributed much of the resistance to “turf wars” and an ingrained belief amongst some senior CAF leaders that when approaching medical issues “the only people that can have a say of any credence are the people who wear the doctor’s symbol on their door.”⁸⁷ He noticed particular pushback from Colonel and chief CAF psychiatrist Randy Boddam in Ottawa. As the OSISS program took shape Grenier believed Boddam felt threatened by the attention given to ideas coming from outside the medical community. He inferred that resistance stemmed from the fact that “now all of a sudden you have this uneducated guy with no PhD, who’s at the same table, and his opinion starts to be valued.”⁸⁸ Joe Sharpe agreed with Grenier’s assessment, affirming that “Randy [Boddam] was a serious obstacle to adopting a new approach to dealing with PTSD ... [I]f he hadn’t come up with an idea, then the idea must be flawed. He had major conflicts with other psychiatrists – most notably Greg Passey.”⁸⁹ Sharpe recalled that during one meeting he attended Passey and Boddam had an especially heated argument that “nearly came to blows.”⁹⁰

Grenier was not the only reformer dealing with resistance from some in Ottawa. Concurrently, as Grenier worked to get OSISS off the ground, Colonel Christian Barabé, the 5 Canadian Mechanized Brigade Group Commander at CFB Valcartier from 2000 to 2002, was concerned about the number of soldier suicides occurring there, and worked with the University of Laval Chair of Occupational Health and Safety Management, Jean-Pierre Brun, to try and root out the problem.⁹¹ Barabé was particularly concerned that at that time there was no holistic effort to understand the psycho-social issues faced by soldiers. Thus he allowed Brun and a Laval

⁸⁶ Richardson et al. “Operational Stress Injury Social Support,” 61.

⁸⁷ Grenier interview.

⁸⁸ Ibid.

⁸⁹ Sharpe, e-mail message to author, November 18, 2014.

⁹⁰ Ibid.

⁹¹ Barabé, Christian. Interview by author. Telephone. Toronto, November 21, 2014.

research team access to the entire Brigade Group and its troops, with the goal of discovering the most common issues. The researchers conducted interviews, spoke with the chain of command, and utilized questionnaires to ascertain what stresses troops were under and how they felt about their workplace environment.⁹² The team used the results to produce a study of the climate prevailing on-base.⁹³

When the “medical system” in Ottawa got wind of his actions, Barabé was advised to cease further studies.⁹⁴ Among other things, the study’s methodology and legitimacy were called into question, much to Barabé’s consternation given the academic credentials of the Laval team.⁹⁵ Like Grenier, Barabé attributed Ottawa research and medical personnel resistance to “turf wars” and a desire to ensure innovations came from the CAF/DND centre rather than periphery.⁹⁶ Regardless, he continued with various initiatives. Several innovations were produced at CFB Valcartier, including the Deployment Support Group, a mix of Regular Force and Reservists whose job was to provide support for families of soldiers overseas and help injured troops back to work.⁹⁷ Joe Sharpe later praised Barabé’s enterprises as one of the first systematic studies of soldiers’ psychological health, and the basic concept of a deployment support group was later utilized for the Joint Personnel Support Unit, discussed below.⁹⁸

While Barabé fought to implement reforms at Valcartier, in Ottawa Stéphane Grenier worked to convince clinicians about the benefits of the OSISS approach. During the program’s development Grenier noticed that clinicians around Canada could be roughly divided into three

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ Ibid; When asked about specifics, Barabé recalled the resistance in Ottawa stemming from staff in the research department of the Chief of Military Personnel.

⁹⁷ Ibid; For more information on the Deployment Support Group see Base Valcartier, “Deployment Support Group.” <http://www.cg.cfpsa.ca/cg-pc/valcartier/en/familyservices/deploymentsupport/Pages/default.aspx> (accessed August 7, 2015).

⁹⁸ Ibid; G.E. Sharpe, e-mail message to author, November 18, 2014.

categories: 33% were extremely supportive, 33% were undecided, and the final third were deliberately or passively obstructive.⁹⁹ From the latter group Grenier encountered “strong resistance” to the idea that OSISS could provide an adjunct, social method of alleviating OSIs. Opposition usually stemmed from the belief that OSIs were a strictly medical subject under the sole purview of the medical community.¹⁰⁰ Grenier was disappointed at how many practitioners initially dismissed a more holistic, lay approach: “I’m not going to start telling doctors what to do with their patients, but it is perfectly understandable and acceptable to actually influence our [military] leadership in how to deal with these matters. Because ... people who have Operational Stress Injury or PTSD, or whatever you want to call it, don’t live in their doctors’ offices. They have to contend day in, day out with society, their family, their workplace, [and] their colleagues.”¹⁰¹ While patients might see their doctor once a week if they were lucky, “at the end of the day, all of it comes together on the ground floor ... where others reside.”¹⁰²

The OSI term and OSISS were in Grenier’s estimation a few of the “the multiple ingredients” necessary to reshape CAF culture and ensure psychologically injured soldiers were supported outside of the clinic as well as within it.¹⁰³ While he battled opposition in Ottawa and elsewhere, Grenier told his first four Coordinators to just “focus on [peer] supporting” mentally injured troops and he would take care of solidifying the program’s expansion.¹⁰⁴ Shortly after OSISS’ beginnings in 2002, he noted a shift among previously undecided clinicians: “[T]hat clinical group of people who were extremely supportive of what we were doing grew rapidly ... because they saw how effective that human connection was and how it could be used as a

⁹⁹ Grenier interview.

¹⁰⁰ Richardson et al. “Operational Stress Injury Social Support,” 62.

¹⁰¹ Grenier interview.

¹⁰² Ibid.

¹⁰³ Ibid.

¹⁰⁴ Ibid.

strategic lever to actually achieve greater and faster therapeutic gains for their patients.”¹⁰⁵ There were, he acknowledged, bumps along the road, and on a few occasions he had to let PSCs go because he “might have chosen the wrong guy.”¹⁰⁶ Nevertheless, the program rolled on, and by 2004 OSISS had over 900 registered serving or retired soldiers on the books.¹⁰⁷ At the time of his retirement in 2012, after a decade of the OSI term’s percolation into CAF circles, Colonel Grenier saw positive steps in how the word “injury” was applied to mental injuries as well as physical ones.¹⁰⁸ Though there was more work to be done, a mental “injury” was no longer always “that term [PTSD] that says ‘that guy has a disorder, what the fuck is wrong with him?’”¹⁰⁹

New War, New Approaches

While metaphorical battles occurred in Canada over how to handle psychological injuries, Canadian troops were engaged in literal battles in Afghanistan. After the lessons of the Croatia Board of Inquiry, CAF and DND officials knew they could not be caught unprepared for a potential rise in the number of troops returning with mental difficulties. Thus, from the beginning of the Afghanistan War, CAF leaders adopted novel approaches to screening troops, conducting post-deployment health checks, and preparing soldiers for reintegration to Canadian society. One decisive break from 1990s peacekeeping deployments involved the introduction of “third location decompression (TLD).” TLD drew on a range of historical, anecdotal, and sociological evidence that soldiers reintegrated more effectively and better “processed” the

¹⁰⁵ Ibid.

¹⁰⁶ Ibid.

¹⁰⁷ Chief Review Services, Department of National Defence and Veterans Affairs Canada. *Interdepartmental Evaluation of the OSISS Peer Support Network*, 1258-138 (CRS). Ottawa: Department of National Defence and Veterans Affairs Canada, 2005, II/V.

¹⁰⁸ Grenier interview.

¹⁰⁹ Ibid.

events of their tour if provided a rest and recuperation period before returning home.¹¹⁰ The most compelling argument for TLD came from Lieutenant-Colonel Pat Stogran, a Bosnia veteran and the first commander of Canadian troops in Afghanistan. Stogran knew the subject well since he had personally experienced difficulties reintegrating after his 1990s peacekeeping tours. He proposed a short stopover and rest for troops prior to their return. The DND promptly accepted his advice.¹¹¹

Thus the first Canadian contingent returning from Afghanistan in 2002 spent several days on the Pacific island of Guam before flying home.¹¹² Ironically, the TLD site was later changed to Cyprus, the island previously described as a vacation spot by Canadian peacekeepers in the 1980s and 1990s. TLD, as the name implied, aimed to provide troops time to rest and decompress before readjusting to civilian society. The Cyprus stay also included information sessions on family and work reintegration, anger management, mental health, and suicide risk awareness.¹¹³ OSISS Peer Support Coordinators were also present to share their own post-deployment stories and explain the organization's role in aiding psychologically injured soldiers.¹¹⁴ While Ombudsman André Marin initially believed TLD was “not a productive or practical approach to addressing reintegration,” particularly since it kept soldiers away from their

¹¹⁰ This topic had been pitched by Navy Captain Margaret Kavanagh in the 1990s, and explored by two Canadian military psychologists, Major P.J. Murphy and Captain G. Gingras, in 1997, but it was apparently not taken seriously by CAF and DND officials until the new millennium. See Marin, *Report to the Minister of National Defence*, 131; The most prominent historical comparison usually contrasted the Second World War with Vietnam, with the former being considered a model way of bringing troops home – slowly and amongst comrades. In Vietnam, as with Canadian peacekeeping operations in the 1990s, soldiers were brought home by plane and in short order, and often scattered to the winds shortly after their return. See Shephard, *A War of Nerves*, 358; previous chapter discussions of Reservists' return.

¹¹¹ Michel Rossignol, Parliamentary Information and Research Service, PRB 07-20E, “Afghanistan: Military Personnel and Operational Stress Injuries” (Ottawa: Library of Parliament, 2007), 1.

¹¹² Ibid.

¹¹³ Ibid.

¹¹⁴ Ibid.

families even longer, in his December 2002 follow-up report he admitted that “so far the majority of CF members and their families view these actions as very positive.”¹¹⁵

Although TLD provided Canadian troops much needed R and R and demonstrated the CAF/DND’s commitment to new strategies for reintegration and maintaining psychological health, after several years’ implementation its efficacy was questioned. An August 2009 *Toronto Star* article based on obtained DND documents claimed “the defence department’s preferred method of treating the mental toll of war is taking a personal financial toll on the troops.”¹¹⁶ Some members, the article reported, were finding quick ways to divest themselves of their salaries and danger pay on Cyprus, largely as a result of soldiers’ timeless and preferred method of processing war experiences – alcohol.¹¹⁷ Military officials running the TLD program recommended briefings on responsible use of money during deployment and a two-drink limit for soldiers’ first night of decompression, but such rules even if created were almost impossible to enforce.¹¹⁸

Master Bombardier Adam Hannaford, who twice deployed to Afghanistan in 2007 and 2008 and was subsequently diagnosed with PTSD, stated that alcohol also had an effect on soldiers’ attention during TLD mental health briefings: “You’re so fucking hung over or still drunk from the night before, you’re just really not paying attention. You’re just thinking, ‘I need some water.’”¹¹⁹ Given the psycho-social and other factors that contributed to reintegration, it

¹¹⁵ Marin, *Report to the Minister of National Defence*, 131; Marin, *Follow-Up Report*, i.

¹¹⁶ *The Toronto Star*, 7 August 2009.

¹¹⁷ Ibid; Some soldiers also got into trouble, and another report cited in a 14 April 2009 *Toronto Star* article stated that some had been injured in drinking establishments, while others had damaged hotel furniture, leading to a 3am curfew time.

¹¹⁸ *The Toronto Star*, 7 August 2009.

¹¹⁹ Hannaford, Adam. Interview by author. Telephone. Toronto, July 21, 2014; According to Lieutenant-Colonel Chris Linford, if soldiers were sick from alcohol during the mandatory morning lectures they would be banned from drinking for the remainder of their stay and in particularly egregious circumstances face disciplinary actions. But, as Hannaford’s testimony demonstrated, some inevitably slipped through the cracks. See Chris Linford, *Warrior Rising: A Soldier’s Journey to PTSD and Back* (Victoria: Friesen Press, 2013), 301.

was difficult to assess TLD's long-term impact on soldiers' mental wellness; but troops, even despite some misadventures, found the experience useful. A 2012 *Military Medicine* article by Drs. Bryan Garber and Mark Zamorski of the Canadian Forces Health Services Group Headquarters in Ottawa stated that although it was tough to appraise TLD as a "medical intervention," sociologically speaking the majority of Forces members supported the TLD concept and found the program to be of value.¹²⁰ Tod Strickland, deputy commander of PPCLI battle group in Afghanistan, agreed with that assessment. Strickland believed that in addition to helping monitor soldiers' immediate post-deployment mental state, TLD also helped troops transition back to "normal standards of behaviour."¹²¹ Behaviours taken for granted in civilian life, such as "[l]eave your boots at the door, stop swearing all the time, wash your hands before you eat" and "[j]ust being civil" were relearned prior to returning to Canada.¹²² For that reason, Strickland argued, TLD made a "big difference" in soldiers' social and mental readjustment.¹²³

Elsewhere, on the battlefield the CAF demonstrated it was also taking a proactive approach to psychological injuries sustained in theatre. While mental health teams were conspicuously missing from numerous peacekeeping operations in the 1990s, CAF leaders made the decision to send a team early in the Afghanistan conflict.¹²⁴ A more novel and radical approach was also taken with regards to traumatic stress.¹²⁵ To bolster the view that PTSD and other psychological injuries were as legitimate as physical wounds, medical officers and mental health teams ensured those treated for post-traumatic stress – but not necessarily diagnosed with

¹²⁰ Bryan Garber and Mark Zamorski, "Evaluation of a Third-Location Decompression Program for Canadian Forces Members Returning from Afghanistan," *Military Medicine* 177, no. 4 (2012): 402.

¹²¹ *The Toronto Star*, 17 February 2007.

¹²² *Ibid.*

¹²³ *Ibid.*

¹²⁴ As noted in chapter four, the CAF had sent a psychiatric team with the Canadian Naval Task Group during the Gulf War in 1991.

¹²⁵ Novel and radical of course only if one does not include the forced return to combat of shell-shocked and exhausted soldiers during the First and Second World Wars.

an OSI – were returned to duty “as soon as possible.”¹²⁶ Citing the unit’s important role as a mental bulwark, trauma surgeon Major Ron Brisebois told the *Toronto Star* that quickly returning traumatized soldiers to active duty “tends to minimize the amount of post-traumatic stress they have.”¹²⁷ The reason was simple: “It allows them to remain with their unit, and stay with their comrades and be accepted as one. It’s probably the best way for them to vent their feelings.”¹²⁸ Though this strategy went largely unnoticed when first reported in 2002, five years later, in March 2007, chief CAF psychiatrist Randy Boddam, then deployed on a four-month tour in Afghanistan, made headlines when he revealed the military was sending some soldiers with OSIs to the Afghan theatre.¹²⁹

The military’s decision to send soldiers with OSIs once more unto the breach highlighted the thorny issues surrounding psychological injuries. Boddam’s view, expressed to the *Globe and Mail*, reflected the CAF leadership’s new attitude toward the problem: “Let’s acknowledge it [mental illness], let’s bring it out of the shadows and get people in so they get treatment sooner, and [sic] be employable and living their lives the best they can.”¹³⁰ He clarified the military’s stance by insisting the Forces did not “deploy knowingly anybody who is suffering from a mental illness that would impair their ability to function in this environment.”¹³¹ Instead, physicians and psychologists sent only those who were on “maintenance phases of their treatment.”¹³² Boddam and Dr. Mark Zamorski, head of the military’s deployment health section in Ottawa, emphasized the vast continuum of mental health states, with Boddam stating “Not all

¹²⁶ *The Toronto Star*, 24 April 2002.

¹²⁷ *Ibid*; Narratives and opinions expressed during the Croatia Board of Inquiry about the social support provided by the unit were evident.

¹²⁸ *Ibid*; This strategy resembled the PIE method utilized in the First and Second World Wars at various points.

¹²⁹ *The Globe and Mail*, 5 March 2007.

¹³⁰ *Ibid*; Boddam’s view had support from military leaders and anecdotal evidence. Lieutenant-Colonel Chris Linford wrote that a soldier’s heightened worry about failure meant that being pulled early from a mission (or not being sent at all) was even more dreaded than staying in theatre. See Chris Linford, *Warrior Rising*, 156.

¹³¹ *Ibid*.

¹³² *Ibid*.

post-traumatic stress disorders are created equal.”¹³³ The problem, and something the Canadian media noted, was that physicians seemed unable to predict the *total* effect that an Afghanistan tour would have on soldiers with OSIs, as well as how an OSI would affect their operational performance. Boddam opined that assuming all else was equal placing soldiers in an operational setting “may not in any way exacerbate their illness.”¹³⁴ On the other hand, Zamorski’s honest but nonetheless unsettling appraisal reflected the reality that any attempt to treat psychological injuries in the same manner as physical ones required a step into the unknown: “Is there somebody who’s died in Afghanistan because they weren’t paying attention because they were mentally ill? It’s possible.”¹³⁵

The revelation that some soldiers with OSIs – particularly PTSD – were being sent to Afghanistan raised a stir amongst politicians and the public, and led to questions in the House of Commons.¹³⁶ Three days after the *Globe and Mail* printed its story Navy Commodore Margaret Kavanagh, Commander of Canadian Forces Health Services Group, wrote a letter to the paper reiterating the CAF’s confidence in its approach:

Canada has deployed, and will continue to deploy, individuals who have been successfully treated for mental or physical illnesses or injuries ... To do otherwise would only perpetuate the stigma around these illnesses and injuries, and continue to drive the problem underground. If we want Canadian Forces members to seek treatment for a mental illness or an operational-stress injury, they need to trust they can be given the opportunity to continue with a full and rewarding career, even with such a diagnosis.¹³⁷

While an aggressive stance toward OSIs might be disagreeable to some Canadians’ sensibilities, in the battle against stigma CAF leaders believed the problem must tackled head on.

¹³³ Ibid.

¹³⁴ Ibid.

¹³⁵ Ibid.

¹³⁶ *The Globe and Mail*, 19 March 2007.

¹³⁷ *The Globe and Mail*, 8 March 2007.

Kavanagh argued that rather than shrinking away from such an approach, Canadians “should be celebrating the success of those who have overcome such problems and returned to active duty.”¹³⁸ Kavanagh’s letter and the CAF’s new approach demonstrated that, in addition to new attitudes, the war against OSIs also required new – and sometimes morally/ethically ambiguous – actions.¹³⁹

Two Steps Forward, One Step Back

The new approach to psychological injuries represented broader efforts by the CAF and DND throughout the first decade of the new millennium to implement reforms in the mental health realm. Those reforms in turn took place under the umbrella of the larger “Rx2000” project, a major initiative to rebuild the entire CAF medical system, including mental health services, after the Cold War.¹⁴⁰ One of the main goals of the new initiatives, as stated by Brigadier-General Lise Mathieu, Director General of Health Services in 2003, was the “gradual reduction of the fear of ‘stigmatization’ as a result of OSI,” though she admitted that “much remains to be done in this area to reach all those afflicted.”¹⁴¹ Mathieu wrote that military health care professionals had “become only too aware of the growing demand on the part of members of the Canadian forces for mental health services, not only for treatment but also for prevention and promotion of psychological fitness.”¹⁴²

¹³⁸ Ibid.

¹³⁹ Once again, it is important to note that in an historical sense this approach was not new, given that shell-shocked soldiers were sent back to duty as far back as the First World War (and likely even earlier), but since most Canadians were unaware of past practices, it certainly seemed new to many.

¹⁴⁰ For more on Rx2000 and an appraisal of its accomplishments and challenges post-2000, see Commodore Hans Jung, “Lessons Learned from the War in Afghanistan: A Leader’s Perspective,” *Canadian Journal of Surgery*, 54, no 6 Supplement (2011): S110-S111.

¹⁴¹ Brigadier-General Lise Mathieu, Director General Health Services, National Defence and the Canadian Armed Forces, “Concept for Canadian Forces Mental Health Care,” unpublished paper (Ottawa: National Defence and the Canadian Armed Forces, 2003), 14/37; Thanks and acknowledgements to Lieutenant-Colonel Suzanne Bailey, Canadian Forces Health Services Group Headquarters, for providing a copy of the paper.

¹⁴² Ibid., ii/viii.

Though a new stance on OSIs pointed to an attitudinal shift amongst senior CAF leaders, there were signs that numerous soldiers were unwilling to part with traditional beliefs about mental illness. Just one year after the 2002 Ombudman's Report on systemic treatment of soldiers with OSIs, André Marin released another report about a 22 November 2002 incident during the "French Grey Cup" at CFB Winnipeg. A long held tradition of the PPCLI since the 1950s, the French Grey Cup was the championship game at the end of the Regiment's intramural football season.¹⁴³ In addition to the game itself, there was also a parade during which soldiers from each company designed their own float.¹⁴⁴ As part of the tradition, one male soldier from each company was also made to dress like a woman – a "queen." The winner, judged to be the most "ravishing," was declared "Miss Grey Cup" and carried off the field by other soldiers.¹⁴⁵ Traditions and entertainment involving gender inversion, and allusions to homosexuality, had a long history in the Canadian military. During the Second World War, for example, male soldiers dressed in drag put on elaborate song-and-dance shows for fellow troops, while others staged mock weddings in which one soldier took on the role of the bride.¹⁴⁶

Aside from the obvious gender connotations, which hearkened back to days when the CAF was an all-male institution, the November 2002 parade had an especially unique float. One 2PPCLI company constructed a float depicting a train pulling a cage.¹⁴⁷ Inside the cage was a young man dressed "provocatively in women's clothing."¹⁴⁸ At first glance the float appeared to

¹⁴³ *The National Post*, 10 March 2003; According to Lewis MacKenzie, the name stemmed from the Regiment's grey uniforms, adopted during the First World War when the Regiment served beside the French Army; On the other hand, according to then 2PPCLI Commanding Officer Lieutenant-Colonel Mike Day the French Grey Cup went back to the First World War, when Canadian soldiers in France participated in an event involving sports competition and a parade. At that time it was called *Les Folles*. See André Marin, Ombudsman National Defence and Canadian Forces, *Off the Rails: Crazy Train Float Mocks Operational Stress Injury Sufferers* (Ottawa: Department of National Defence, 2003), 10.

¹⁴⁴ The number usually totaled five or six. See *ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ For an excellent analysis of such practices during the Second World War, see Jackson, *One of the Boys*, 66-74.

¹⁴⁷ Marin, *Off the Rails*, 3.

¹⁴⁸ *Ibid.*

simply portray a caged man “in drag,” but further details demonstrated it carried a different message. The Ombudsman’s investigation revealed that the float also had the words “2PPCLI Express” and “Next Stop North Side” written on it.¹⁴⁹ While some interviewees prevaricated about the meaning, and an internal investigation concluded in December 2002 that the float did not reference mental illness, the Ombudsman’s findings confirmed the float was indeed meant to mock perceived malingerers diagnosed with OSIs.¹⁵⁰ The “North Side” colloquially referred to the north area of CFB Winnipeg, which housed the 17 Wing of the Air Force. The 17 Wing provided health and social services to 2PPCLI members, including soldiers diagnosed with OSIs who had been reassigned for health reasons to employment in the base’s northern area.¹⁵¹ In popular parlance, those diagnosed with OSIs were said to be going “to the North Side on the Crazy Train,” with the latter term being an allusion to the 1980 song “Crazy Train” by musician Ozzy Osbourne.¹⁵² For 2PPCLI members the meaning was self-evident. One soldier interviewed by the Ombudsman’s team stated that “everybody right up to the CO [commanding officer] knows what the Crazy Train is.”¹⁵³

The Ombudsman’s investigation concluded there was “a widespread perception within 2 PPCLI that a significant number of members who have been diagnosed with OSIs are faking or exaggerating their symptoms. The perception is that they are doing this in order to obtain advantages that are not available to other members, such as occupational transfers and/or pensions.”¹⁵⁴ Although the float was apparently intended to deride only those deemed malingerers, the message affected all members with OSIs in a similar manner. Former Croatia

¹⁴⁹ Ibid., 12; The float also had, in smaller lettering, a sign saying “CT-01” on it, the CT being short for “Crazy Train.” For a picture of the float see *ibid.*, 12.

¹⁵⁰ Ibid., 9; For more on the 2PPCLI leadership’s reaction to the float see *ibid.*, 19-22.

¹⁵¹ Ibid.

¹⁵² Ibid.

¹⁵³ Ibid., 10; In an interview with the author, Mike Spellen, who was working with OSISS during the time of the incident, confirmed that the term “crazy train” was well known to 2PPCLI members.

¹⁵⁴ Ibid., 9.

Board member Mike Spellen was an OSISS Peer Support Coordinator at the time of the incident and recalled receiving a phone call on 29 November 2002 about the parade float: “There were two guys that were pulling that float that were suffering from PTSD, unannounced to the idiots that made them pull this float.”¹⁵⁵ Moreover, a civilian worker told Spellen that a 2PPCLI member experiencing psychological difficulties stated he was reluctant to seek treatment because the battalion looked unfavourably upon OSIs, citing the aforementioned parade float as an example of the unit’s hostility.¹⁵⁶ Angry at the float’s connotations and 2PPCLI leaders’ attempts to downplay the incident, Spellen made a complaint with OSISS Program Manager, then Major Stéphane Grenier, and subsequently contacted the Ombudsman’s office.¹⁵⁷

Marin and his team, led once again by Gareth Jones, Lead Investigator of the McEachern complaint, concluded the float mocked OSI sufferers, that the battalion’s internal investigation was “neither thorough nor objective,” and that “much work” was left to be done.¹⁵⁸ The Crazy Train incident once again highlighted the inherent problems when attempting to comprehensively penetrate CAF culture and traditional attitudes about mental illness. The incident also brought out prominent commentators. Several days after the Ombudsman’s report was released and scrutinized by Canadian news outlets, retired Major-General Lewis MacKenzie weighed in on the controversy in a 10 March 2003 *National Post* article. MacKenzie expressed dismay that “at the very moment this country is trying to decide if we should be putting our military in harm’s way ... Canada’s military ombudsman, is focused on the design of a company float during a 2PPCLI unit celebration ... Only in Canada, I hear you say.”¹⁵⁹ Himself a retired PPCLI member, MacKenzie believed the French Grey Cup parade was nothing more than a fun

¹⁵⁵ Spellen interview; Marin, *Off the Rails*, 19.

¹⁵⁶ Marin, *Off the Rails*, 19.

¹⁵⁷ Spellen interview; Marin, *Off the Rails*, 5.

¹⁵⁸ Marin, *Off the Rails*, 3; The incident also, unsurprisingly, made national news. See for example *The Globe and Mail*, 6 March 2003.

¹⁵⁹ *The National Post*, 10 March 2003.

and silly tradition.¹⁶⁰ He also pointed out that the float in question was investigated “as as a result of a single complaint,” hardly, in his mind, a sign of larger problems.¹⁶¹ MacKenzie’s overall take was that for 2PPCLI members and leadership “there was nothing in Marin’s report to accept responsibility for!” He summed up his stance by stating: “Soldier’s humour can be pretty black at times, but in this case it was pretty good; an upfront attempt to send a message to those soldiers who use feigned operational stress injuries to excuse their behaviour or seek medical release with compensation.”¹⁶² MacKenzie’s response to the Crazy Train incident and subsequent investigation reminded soldiers that “Regimental tradition is more important than a backhand slap from someone [Marin] who has not walked the walk.”¹⁶³ In a further nod to traditional views of the ideal soldier, MacKenzie’s rebuttal was also, in his own words, a counterattack against Marin and others reformers’ “‘touchy feely’ philosophy.”¹⁶⁴

Although unpalatable to some, MacKenzie’s viewpoint spoke to those who valued traditional attitudes and believed that an increased focus on OSIs created further problems in the form of malingering. That belief was a perennial concern for those who viewed psychological injuries in an unfavourable light, and had roots as far back as the First World War. MacKenzie’s

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

¹⁶² Ibid; MacKenzie’s view also spoke to those who had read about stories of a small number of CAF members fraudulently using PTSD as an excuse for criminal behaviour. One particularly troubling example was the case of Roger Borsch. A Bosnia veteran, Borsch was criminally charged in 2004 for breaking into the home of a co-worker in The Pas, Manitoba and sexually assaulting the woman’s thirteen-year-old daughter at knifepoint. The defence claimed he suffered from PTSD as a result of his peacekeeping experiences and was unaware of his actions. A Manitoba Court of Queen’s Bench in June 2006 initially found Borsch not guilty by reason of mental disorder, marking the first time that a Canadian soldier successfully used PTSD as a defence in a criminal trial. His former commander, retired Colonel Ray Wlasichuk (who also testified at the Croatia BOI several years earlier) became aware of the story and later exposed Borsch’s traumatic peacekeeping stories as lies to the *Globe and Mail*. In September 2007 a Manitoba Court of Appeal, citing Justice Nathan Nurgitz’s insufficient explanation of his reasoning for ruling Borsch not guilty, overturned the decision. Borsch, sensing his ruse was up, pled guilty at the subsequent trial, stating that it may have been alcohol, not PTSD, which was the precipitating factor in his actions. He was sentenced to two years in prison. Such cases, though rare, did much to fuel the fire of those who believed that the dangers of malingering and fakery were widespread. See *The Toronto Star*, 23 June 2006; 6 March 2007; 28 September 2007; and *The Globe and Mail*, 24 June 2006; 13 September 2008.

¹⁶³ *The National Post*, 10 March 2003.

¹⁶⁴ Ibid.

arguments also addressed concerns that, in a consistently understaffed military, there were nonetheless always men and women looking for the proverbial free ride. As just one example, Master Bombardier Adam Hannaford was diagnosed with PTSD but initially hesitant to accept his condition because he believed some other soldiers were feigning the disorder for personal gain. He recalled: “It’s like, OK well if *this* person’s [a supposed malingerer] got it [PTSD] then I can’t have it. How the fuck can I justify it?”¹⁶⁵ Hannaford expressed “disgust” at what a particular soldier “got” and how she “played the system so well,” stating that “it’s people like that [malingerers] that make it difficult for people like me ... or people that are in that situation similar to me.”¹⁶⁶ Hannaford’s view, and MacKenzie’s similar take, demonstrated that despite professionally estimated low percentages of “fakers,” there were strong beliefs that a greater acceptance and willingness to discuss OSIs led to many individuals milking the system.¹⁶⁷

The problem with adopting such a stance, though, was that exactly who was malingering and the true extent of the problem were subjectively determined conclusions when made by anyone but professionals.¹⁶⁸ In a discussion with the author, retired Brigadier-General Christian Barabé, Commander of Land Force Québec / Joint Task Force (East) from 2005 to 2008, said that a small number of individuals “abusing the system because of the openness” about PTSD was a fact of life, but those cases “should normally be picked up by the [medical] specialist.”¹⁶⁹ In Barabé’s estimation, some malingerers slipped through the cracks only because military medical specialists were overworked and thus unable to dedicate a proper amount of time to

¹⁶⁵ Hannaford interview.

¹⁶⁶ Ibid.

¹⁶⁷ Those subscribing to that belief certainly could find statistics to back up their argument. For example, in May 2004 the *Toronto Star*, using obtained military documents, reported that depression and PTSD were the highest reasons for sick leave. Depression accounted for one in five sick days, while PTSD accounted for one in ten. This increase was attributed by those preparing the documents for the CAF’s Chief of Defence Staff to a greater strain being put on a small CAF. Nonetheless, such documents could also be used to bolster a belief that mental illness was overblown and that some were abusing the system.

¹⁶⁸ And, one might argue, given the historical evidence, even when made by professionals.

¹⁶⁹ Barabé interview.

learning each case's specifics.¹⁷⁰ Consequently, a number of rank-and-file soldiers were "aware of those who are abusing the system," and therefore saw those cases as evidence that psychological injuries were illegitimate.¹⁷¹ That knowledge sometimes led to instances of shaming perceived malingerers, demonstrated in the extreme by the Crazy Train incident. Unfortunately, such actions had the effect, even if unintentional, of pushing real OSI sufferers further into the shadows.

A New Dawn?

In spite of the Crazy Train incident, by the first decade of the new millennium it was clear that CAF/DND initiatives, the work of reformers, and consistent media interest had led to a more open dialogue and greater acceptance, at least in theory, of soldiers with psychological injuries. A new consciousness about psychological trauma emerged in both military and civil society. One noticeable trend was more frequent media investigations dissecting and explaining psychological trauma amongst Canadian soldiers of all generations, especially veterans of the 1990s and beyond.

Although discussions of mental illness among Canadian soldiers and veterans were few and far between in preceding decades, several documentaries appeared throughout the 2000s. The first was a November 2001 documentary titled *War Wounds & Memory*, directed by Vancouver-based filmmaker Brian McKeown. Aired by the CBC on Remembrance Day 2001, *War Wounds & Memory* examined the plight of Canadian Vietnam War veterans and the struggle

¹⁷⁰ Ibid.

¹⁷¹ Ibid.

to find meaning in their service whilst simultaneously fighting PTSD.¹⁷² McKeown was, in his own words, “pre-disposed” to the subject.¹⁷³ His own father, a First World War combat veteran, had a “darkness about him,” and as with many veterans of that conflict, “had nightmares until the end, always about the war.”¹⁷⁴ McKeown’s interest in making a film about traumatized Canadian veterans thus stemmed from: his father’s experiences; an introduction in the late 1990s to a group of Canadian Vietnam vets living in Vancouver; and an “insight and fresh understanding of combat trauma that has taken place from the 1990’s to the present day.”¹⁷⁵

Media interest unsurprisingly shifted to the Afghanistan War’s effect on soldiers’ minds. In the lead-up to Remembrance Day 2009, the popular CBC program *The Fifth Estate* aired an episode titled “Broken Heroes” about Afghanistan veterans with PTSD.¹⁷⁶ Featuring candid interviews with Roméo Dallaire as well as rank-and-file soldiers, “Broken Heroes” focused on the psychological costs of modern war. Among other topics, the program examined the darker side of avoiding treatment, with one soldier describing his descent from healthy living to cocaine and alcohol addiction.¹⁷⁷ Soldiers also discussed the self- and culturally-imposed stigmas attached to psychological “weakness” amongst those built up to feel invincible.¹⁷⁸ Chief of the Defence Staff Walter Natynczyk, while citing the great progress made in retaining soldiers with stress injuries, nonetheless highlighted the military’s perennial challenge:

We permeate the culture, that kind of warrior culture, where we want people to be warriors. We want them [warriors], because they have to go into harm’s way at sea, at 40,000 feet in the air, or in places like Afghanistan. We need that. We need them to be

¹⁷² *War Wounds & Memory*, directed by Brian McKeown (2001; Vancouver: Howe Sound Films Inc., 2001), DVD; Acknowledgements and thanks to Mr. McKeown for providing a copy of the film, for sharing recollections on reasons for the film’s creation, and for kindly sharing his family’s military history.

¹⁷³ Brian McKeown, e-mail message to author, November 7, 2014.

¹⁷⁴ Ibid.

¹⁷⁵ Ibid.

¹⁷⁶ “Broken Heroes,” *The Fifth Estate*. Canadian Broadcasting Corporation (Toronto: CBC, October 30, 2009).

¹⁷⁷ Ibid.

¹⁷⁸ Ibid.

adventurous. We need them to be strong of heart. But at the same time we need them to be accepting, that we're not all in armour suits; and that when we do have a problem, that they go in for assistance.¹⁷⁹

Moreover, although there was a louder dialogue about stress injuries and greater efforts made to retain those afflicted, the reality was that, historically, most of those diagnosed with PTSD left the military or were discharged.¹⁸⁰ When asked by the program's interviewer whether those statistics suggested it was better for soldiers to "suffer in silence," Natynczyk countered that the "emphasis here is on recovery."¹⁸¹ Natynczyk's response subtly acknowledged that mental recovery and a continuing career in the military were still often incompatible goals.

A 2011 documentary *War in the Mind*, produced by TVOntario and narrated by Canadian actor Paul Gross, likewise focused on the dilemmas facing Afghanistan veterans.¹⁸² *War in the Mind* once again featured interviews with prominent figures like Dallaire and Mental Health Adviser to the DND Dr. Rakesh Jetly, as well as emotional recollections by traumatized rank-and-file troops. A well-balanced appraisal of both reforms and obstacles, the documentary exposed the reality that despite significant initiatives such as TLD and peer support programs, old prejudices persisted, with Gross reminding viewers that "militaries are still macho cultures, and especially at the lower levels, the 'suck it up' factor still exists."¹⁸³ As one example of enduring attitudes, an unidentified veteran told the story of a traumatized comrade whose peers often snuck up behind him and yelled "boo" to provoke a startle response.¹⁸⁴ The storyteller lamented: "They think it's a joke, they think it's funny because they don't understand ... because

¹⁷⁹ Ibid.

¹⁸⁰ Ibid.

¹⁸¹ Ibid.

¹⁸² *War in the Mind*. TVOntario (Toronto: TVOntario, August 2, 2011).

¹⁸³ Ibid.

¹⁸⁴ Ibid.

they didn't experience it themselves."¹⁸⁵ Such examples were, in Dallaire's mind, evidence that it was necessary to continue the battle and slowly "wear down the system."¹⁸⁶

In addition to a greater number of documentaries and television programs, another outgrowth of the new national consciousness about psychological injuries was the willingness of soldiers to publish autobiographical accounts about their struggle with PTSD. After Dallaire's influential 2003 book *Shake Hands with the Devil*, other Canadian soldiers were encouraged to write about how PTSD had affected their lives. Retired Bosnia veteran Captain Fred Doucette's 2008 book *Empty Casing* not only described his traumatic peacekeeping experiences in Sarajevo, but also provided a vivid description of how he slowly transformed from "tough soldier" unwilling to admit any weakness, to becoming an OSISS Peer Support Coordinator in 2002.¹⁸⁷ Doucette discussed many of the unique problems inherent when dealing with OSIs, not the least of which was that recovery, when possible, often took several years or more.¹⁸⁸ As one example he wrote that even long after his peacekeeping tours, the sight of a pumpkin on Halloween could still conjure up images of a mangled human head.¹⁸⁹ Like Dallaire, Sharpe, Grenier, and other champions for CAF cultural reforms, Doucette emphasized that despite evident progress there was a long battle ahead: "It will be a long time before the system will consider an OSI an honourable injury, one that is treatable and not a sign of weakness."¹⁹⁰ He concluded his autobiography by reminding readers of the nation's responsibility for soldiers injured during

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

¹⁸⁷ Doucette, *Empty Casing*, 200; Doucette was approached by Grenier to be involved with OSISS in April 2002. See *ibid.*, 210.

¹⁸⁸ Ibid., 207.

¹⁸⁹ Ibid., 215.

¹⁹⁰ Ibid., 214; Doucette further predicted that it would "take a generation of soldiers admitting to OSIs before an OSI is considered an honourable injury and one that you can treat and recover from." See *ibid.*, 218.

service, declaring that the last things troops wanted was “to be discarded like an empty [shell] casing and left on the battlefield to disappear into the dust.”¹⁹¹

Retired Lieutenant-Colonel Chris Linford, a Gulf War, Rwanda, and Afghanistan veteran with over thirty years’ experience with the Regular Force and Reserves, likewise wrote about PTSD’s effect on his life in his 2013 book *Warrior Rising*. Inspired by Dallaire’s example, Linford wrote a candid account of how treatment and understanding brought him back from the brink after traumatic experiences, particularly in Rwanda, led to his mental deterioration.¹⁹² Similar to many soldiers of the 1990s, Linford’s peacekeeping and war experiences haunted him for a long time – ten years – before he was diagnosed with PTSD.¹⁹³ In that time, he began to feel he was gradually experiencing “the loss of my soul as a human as well as my identity as Chris Linford.”¹⁹⁴ Unlike soldiers’ previous works, Linford’s book directly addressed how masculine norms and expectations affected his decision to avoid genuinely addressing thoughts and emotions.

In an especially poignant anecdote, Linford described leaving for the Gulf War and his nervousness about crying in front of his wife: “I think most males of our society would have similar fears given how we were educated as young boys regarding displays of emotion.”¹⁹⁵ Carrying the burden of stoicism on his shoulders, Linford described feeling “shame, weakness and failing as an officer and a man” when he finally admitted to himself that he could not handle PTSD alone.¹⁹⁶ But as he received treatment and came to terms with his situation, he noticed the value in accepting vulnerability as an inevitable part of life for anyone: “I had never felt stronger

¹⁹¹ Ibid., 214.

¹⁹² Chris Linford, *Warrior Rising*, passim.

¹⁹³ Ibid., 189.

¹⁹⁴ Ibid., 329.

¹⁹⁵ Ibid., 19.

¹⁹⁶ Ibid., 171.

about who I was and how I needed to think about myself in the future.”¹⁹⁷ Linford praised the work of OSISS and the Outward Bound Veterans’ Program, a course designed to help mentally and physically wounded veterans utilizing outdoor activities and teamwork, with assisting in his recovery.¹⁹⁸ He reiterated the argument, made by several reformers throughout the 1990s and 2000s, that treating psychological injuries was not just a medical responsibility, but a social one as well. He declared that, “Peer support extends to all of Canada! The importance of the ‘Community’ to the returning Veteran cannot be understated! It can take many forms, from a peer group, to family, to all neighbours and friends, and indeed the whole country.”¹⁹⁹ Like Doucette, Linford emphasized that psychological injuries were treatable if CAF members sought help and openly addressed mental difficulties. Both autobiographies were a testament to the power of social support and a call for the military and Canadian society to cast off unrealistic expectations placed on civilian men and soldiers. They were also a testament to a new and persistent dialogue about psychological injuries that began in the 1990s and by the mid-2000s brought trauma into the Canadian national consciousness.

The New Veterans Charter and Pension Problems

Discussions throughout the decade about psychological injuries also took place against the backdrop of evolving policies towards Canadian veterans. On 13 May 2005, the House of Commons unanimously passed the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, popularly known as the “New Veterans Charter (NVC).”²⁰⁰ Designed as

¹⁹⁷ Ibid., 328.

¹⁹⁸ Ibid., 347-349; For more on Outward Bound, see Outward Bound Canada, Veterans’ Program. http://outwardbound.ca/course_index.asp?Category=110 (accessed January 30 2014).

¹⁹⁹ Linford, *Warrior Rising*, 359.

²⁰⁰ Jean-Rodigues Paré, Parliament of Canada. “The New Veterans Charter.” Library of Parliament Research Publications. <http://www.parl.gc.ca/Content/LOP/ResearchPublications/2011-84-e.htm> (accessed February 10, 2015); The NVC was the brainchild of the Liberal government under Prime Minister Paul Martin but was

a “living charter” to supersede the *Pension Act*, an act that had remained largely the same since the first version was passed in 1919, the NVC provided a series of career transition services, rehabilitation services, vocational assistance, and of course, disability awards for ill or injured Canadian veterans.²⁰¹ The NVC’s emphasis was on helping veterans transition to civilian life. Implemented in April 2006, the Charter came under intense scrutiny and criticism when it became popularly known that the Disability Award within the NVC replaced a previous lifelong disability pension scheme for ill or injured veterans with a one-time, tax-free payment that as of 2013 was capped at \$298,587.97.²⁰² An investigation by the *Toronto Star* disclosed in November 2010 that the average payout was \$38,000.²⁰³ The capped lump-sum payment, which, as revealed by long-time *Toronto Star* columnist Rosie DiManno, was far less than that offered to British and Australian soldiers, became in many peoples’ estimation “The core failing of the Charter.”²⁰⁴

For those released from the CAF due to psychological injuries, the lump-sum payment could prove an especially tantalizing way to spend away their troubles. Mike Spellén, who counselled many traumatized young veterans with varying substance abuse issues while working as an OSISS Peer Support Coordinator, described the main problem with the new approach:

So here you’ve got a guy that’s an addict, self-medicating, PTSD ... and everything else, and he could have a gambling addiction. You’re going to give him “X” number of thousands of dollars one-time payment. And those guys will blow that in a weekend ... And now you’ve got an angry vet ... Because if a guy’s twenty [years-old] or something like that, at least if you gave him money every month and he’s still got his addiction and you’re getting him some treatment, hopefully down the road he’s [going to break the

implemented by the Conservatives after the Liberals lost the 2006 federal election. It was first discussed by Conservative leader Stephen Harper, then Liberal Prime Minister Paul Martin, NDP leader Jack Layton, and Bloc Québécois leader Gilles Duceppe during a flight home from The Netherlands in May 2005 after commemorating Canada’s efforts to defeat Nazi Germany and liberate Holland. See *The Toronto Star*, 6 November 2010.

²⁰¹ Ibid.

²⁰² Veterans Affairs Canada, “New Veterans Charter.” <http://www.veterans.gc.ca/eng/news/vac-responds/just-the-facts/new-veterans-charter> (accessed November 2, 2014).

²⁰³ *The Toronto Star*, 6 November 2010.

²⁰⁴ *The Toronto Star*, 20 September 2010; DiManno noted that in the U.K. total disability carried compensation worth \$850,000, while in Australia veterans had the option of choosing either a lump sum or lifelong pension.

addiction]. But, you know, they do a one-time settlement for these guys and that might be worth five or ten years of payments, but you've still got the guy with the problem.²⁰⁵

Rosie DiManno agreed with the spirit of Spellen's assessment, noting that a *Toronto Star* investigation revealed some young vets "jumped at the lump sum offer that looks appealing to a person in their mid-20s who has a poor grasp of the long-term future."²⁰⁶ Numerous men and women, DiManno stated, "youthful, with little financial guidance – have blown it on stuff rather than arrange investments and structured money management."²⁰⁷

Veterans' Ombudsman and former Afghanistan commander Colonel Pat Stogran publicly criticized the NVC. Appointed in 2007 as the first Veterans' Ombudsman, Stogran turned out to be more than Veterans Affairs and the federal government bargained for. As the Afghanistan War – the longest war Canada had ever participated in – came to a close, and an increasing number of wounded soldiers returned, there was strong evidence that old departmental attitudes persisted despite the new Charter's creation. After three years on the job and receiving countless veterans' complaints Stogran said Veterans Affairs had an "insurance company culture of denial" that placed financial savings at the top of the organization's priority list.²⁰⁸ He further added there was "an overwhelming perception within the veterans community that they're being cheated," and after three years he had "seen the evidence" behind their claim.²⁰⁹

Stogran's appraisal sounded eerily similar to claims made by numerous serving soldiers and veterans during the Croatia Board of Inquiry ten years earlier, and fuelled several media reports that there was "complete onus on the veteran to prove that he or she has been grievously and irreversibly harmed, with no reasonable prospect of returning to service or the civilian labour

²⁰⁵ Spellen interview.

²⁰⁶ *The Toronto Star*, 20 September 2010.

²⁰⁷ Ibid.

²⁰⁸ *The Toronto Star*, 6 November 2010.

²⁰⁹ Ibid.

force.”²¹⁰ A study reported in the *Globe and Mail* by academics Alice Aiken and Amy Buitenhuis at Queen’s University compared financial benefits under the *Pension Act* and NVC and further criticized the latter legislation. The most pertinent aspect was its conclusion: “Our study demonstrates that veterans are financially disadvantaged under the New Veterans Charter. In addition, the compensation gap between the [New Veterans] charter and the Pension Act widens if a veteran lives longer, has more children, has a higher disability assessment or is released at a lower rank.”²¹¹ In Stogran’s view, as he stated before a House of Commons committee in October 2010, the NVC was “clearly an attempt to unload the financial liability, the long-term financial burden that the government carries with injured, wounded veterans.”²¹²

Unsurprisingly, Stogran’s vocal and frank judgements convinced the Conservative government to avoid reappointing him to a second term, with Veterans Affairs Minister Jean-Pierre Blackburn saying it was “time for a new ombudsman to offer a new perspective.”²¹³ Nonetheless, during his final months in the position in late 2010 Stogran made it clear he would not walk away quietly. In August 2010 he declared the Veterans Ombudsman position was just “window dressing” for an “obstructive and deceptive” bureaucracy, and said that one of his final missions was to let Canadians “know how badly so many of you are being treated.”²¹⁴ Then Chief of Defence Staff Walter Natynczyk, Canada’s top-ranking soldier, avoided commenting directly on the government’s decision not to reappoint Stogran, but nevertheless stated during a news conference in August 2010 that Stogran had “certainly voiced with clarity what the issues are.”²¹⁵ Stogran continued his battle even after his term ended, and in March 2013 told the CBC that veterans with PTSD were being denied treatment, and in some cases pensions, after their

²¹⁰ *The Toronto Star*, 20 September 2010.

²¹¹ *The Globe and Mail*, 24 August 2010.

²¹² *The Toronto Star*, 6 November 2010.

²¹³ *The Globe and Mail*, 18 August 2010.

²¹⁴ *Ibid.*

²¹⁵ *The Globe and Mail*, 21 August 2010.

release. He summed up the situation as “different time, different place, but same old story,” describing the VAC system as “an empty shell of treatment and services.”²¹⁶ Stogran vociferously advocated on behalf of soldiers and veterans, and as a popular and experienced leader, his opinions contributed to a reappraisal of the “living charter.”

In September 2010, the Conservative government under Prime Minister Stephen Harper announced new measures to address the needs of the country’s severely wounded soldiers. The government earmarked an additional \$2 billion dollars for VAC programs, which benefitted an extra 4,000 veterans over the next five years.²¹⁷ Also included in the new measures was a lifetime \$1000 monthly stipend for approximately 500 veterans so severely injured that they were not expected to work again in their lifetime.²¹⁸ Those recipients of a Disability Award were also now provided three options: “a lump-sum payment,” “an annual installment over the number of years of a Veteran’s choosing,” or a combination of the two.²¹⁹ The payment still, however, comprised a lump sum paid until the total amount awarded was reached, rather than a lifelong monthly pension. Stogran said he was “encouraged” by the government’s move, but still worried about the way the VAC system “set the bar as high as any insurance company in Canada in the interests of preserving the public purse ... when the legislation actually directs it should be liberally interpreted.”²²⁰ He believed the system was still “severely broken” and there was a “black hole of bureaucrats” who had a “deny, deny, deny” method of handling soldiers’ claims.²²¹ Master Corporal Paul Franklin, an Afghanistan veteran who lost both legs during a

²¹⁶ Donna Carreiro, Canadian Broadcasting Corporation. “Ex-veterans’ Ombudsman Treated for Post-Traumatic Stress.” <http://www.cbc.ca/news/canada/manitoba/ex-veterans-ombudsman-treated-for-post-traumatic-stress-1.1303470> (accessed January 15, 2014).

²¹⁷ *The Globe and Mail*, 20 August 2010.

²¹⁸ *Ibid*; That number included both the physically and mentally wounded.

²¹⁹ Veterans Affairs Canada, “Additional Details on the Enhanced New Veterans Charter Act.” <http://www.veterans.gc.ca/eng/news/viewbackgrounder/7> (accessed January 23, 2015).

²²⁰ *The Globe and Mail*, 20 September 2010.

²²¹ *Ibid*.

suicide bombing in 2006 and was the subject of a 2007 book, said the measures were a “good start” but did not believe the financial commitment of \$1000 a month for severely injured soldiers was “anywhere near enough.”²²² He further added his wish that the lump-sum award be increased.²²³ For his part, Minister of National Defence Peter MacKay denied that Stogran’s grievances were a factor in the new changes.²²⁴ In March 2011 Parliament passed the *Enhanced New Veterans Charter Act*.²²⁵

Ottawa Reacts

As soldiers’ pension issues and psychological difficulties became persistent news items, the CAF and federal government responded in several ways. One important initiative was the 2007 announcement of five OSI clinics administered by Veterans Affairs to help CAF members, veterans, and their families.²²⁶ Located in population centres across the country, and later with satellite clinics established for rural regions, OSI clinics provided “assessment, treatment, prevention and support to serving CAF members, Veterans and RCMP members and former members.”²²⁷ Family members of the above groups were also entitled to receiving some of the available services.²²⁸ Each clinic had a team consisting of psychiatrists, psychologists, social workers, and mental health nurses, with one of the main aims being the mitigation of

²²² Ibid; For the inspiring story of Franklin’s transition after his injuries see Liane Faulder, *The Long Walk Home: Paul Franklin’s Journey from Afghanistan – A Soldier’s Story* (Victoria: Brindle and Glass Publishing, 2007).

²²³ *The Globe and Mail*, 20 September 2010.

²²⁴ Ibid.

²²⁵ Ibid; For more information on the Act see Justice Laws Website, Government of Canada. *Enhanced New Veterans Charter Act*. http://laws-lois.justice.gc.ca/eng/annualstatutes/2011_12/page-1.html (accessed July 20, 2015).

²²⁶ *The Toronto Star*, 20 March 2007; The first five clinics were located in Montreal, Quebec City, London, Winnipeg, and Calgary. At the time of writing there are nine clinics.

²²⁷ Veterans Affairs Canada, “Network of OSI Clinics.” <http://www.veterans.gc.ca/eng/services/health/mental-health/understanding-mental-health/clinics> (accessed January 28, 2015).

²²⁸ Ibid.

psychological issues resulting from mental disorder through therapy sessions.²²⁹ The clinical team also liaised with community practitioners to ensure follow-up care was provided and no one in need slipped through the cracks.²³⁰ Along with OTSSCs, OSI clinics supplied another layer of treatment and social support for the numerous men and women that required help after Afghanistan and earlier deployments.

By December 2008, when almost 5,000 of the CAF's 87,000 Regular Force troops and Reservists were receiving mental health care in one form or another, the government earmarked even more money for OSIs.²³¹ That announcement came on the heels of Mary McFadyen's December 2008 Ombudsman report which showed that staff shortages were a detrimental factor at some bases, such as CFB Petawawa, where 5,100 military personnel were served by only one psychologist and one psychiatrist; requiring many to travel over 160 kilometres to Ottawa for help.²³² That number was in strong contrast to CFB Valcartier, which had eight psychologists and four psychiatrists for 4,500 troops.²³³ Given that Petawawa was "the home base for many of the recent deployments to Afghanistan" at that time, it was unsurprising that the Ombudsman's investigators discovered soldiers were "having difficulty accessing timely mental health care services."²³⁴ McFadyen's report highlighted that strenuous workloads were an issue for many CAF health care specialists, and made attracting and retaining clinicians difficult. In the case of OTSSCs, staff shortages made outreach more "incremental," since there was a "serious shortage

²²⁹ Ibid.

²³⁰ Ibid.

²³¹ *The Toronto Star*, 20 December 2008.

²³² Mary McFadyen, Interim Ombudsman National Defence and Canadian Forces, *A Long Road to Recovery: Battling Operational Stress Injuries – Second Review of the Department of National Defence and Canadian Forces' Action on Operational Stress Injuries* (Ottawa: Department of National Defence, 2008), 13-14.

²³³ Ibid., 13.

²³⁴ Ibid.

of time available for most mental health professionals,” despite “adequate funds.”²³⁵ There were evident challenges for the future.

Another important augmentation for existing services was the 2008 creation of the Joint Personnel Support Unit (JPSU).²³⁶ Commanded in Ottawa by the Director Casualty Support Management, the JPSU was the central administrative unit which oversaw Integrated Personnel Support Centres (IPSCs) dotted across the country, aiming “to provide comprehensive care and integrated support for ill and injured members and their families.”²³⁷ Essentially, the JPSU ensured uniform access to care and consistent approaches throughout Centres nationwide.²³⁸ Put another way, the JPSU, and the IPSCs it oversaw, were intended as a “one-stop service” for soldiers and families, with the JPSU playing a “central [administrative] role in the transition process for CF personnel recovering from serious illness or injury, and either progressing towards a normal work schedule or preparing for a civilian career.”²³⁹ Whereas previously injured members had to seek out medical, financial, and vocational resources themselves, the JPSU connected members with those services and cut down on efforts to obtain support and care.²⁴⁰ Nevertheless, although a step in the right direction, perspectives still varied on the JPSU’s effectiveness. Some felt that removing ill and injured members from the “family structure” of their unit and peers during a period of vulnerability was “an abdication of the fundamental leadership principle of caring for one’s own.”²⁴¹ Brigadier-General Christian

²³⁵ Ibid., 34.

²³⁶ The JPSU replaced the earlier Service Personnel Holding List and even earlier Medical Patient Holding List. For more information on both see André Marin, *Systemic Treatment of CF Members with PTSD*, 141-162.

²³⁷ Pierre Daigle, Ombudsman National Defence and Canadian Forces, *On the Homefront: Assessing the Well-Being of Canada’s Military Families in the New Millennium* (Ottawa: Department of National Defence, 2013), 27.

²³⁸ National Defence and the Canadian Armed Forces, “The Joint Personnel Support Unit, Backgrounder, May 28, 2009.” <http://www.forces.gc.ca/en/news/article.page?doc=the-joint-personnel-support-unit/hnps1uqv> (accessed November 22, 2014).

²³⁹ Ibid.

²⁴⁰ Pierre Daigle, *Fortitude Under Fatigue: Assessing the Delivery of Care for Operational Stress Injuries that Canadian Forces Members Need and Deserve* (Ottawa: Department of National Defence, 2012), 20.

²⁴¹ Ibid.

Barabé believed having a centralized command system in Ottawa for ill and injured soldiers meant “you detach the responsible [local] authorities from actually what’s happening on the ground.”²⁴² As with other reforms of the new millennium, there was divided opinion on how to construct a comprehensive system of care.

Moreover, for psychologically injured troops, there were other obstacles to overcome. The universality of service principle, which was still intact in the second decade of the twenty-first century, meant that injured personnel, including those diagnosed with OSIs, had a finite amount of time to either return to normal duties or face release.²⁴³ As more soldiers posted to the JPSU with psychological injuries from Afghanistan and earlier peacekeeping operations were released, there was, Ombudsman Pierre Daigle stated in 2012, “a sense on the part of some that an organizational promise was made [to retain psychologically injured soldiers] and then reneged upon.”²⁴⁴ There was a persistent view that going to the IPSCs and being posted to the JPSU were a “kiss of death” for a soldier’s career. That belief prevented an unknown but likely significant number of soldiers from seeking care.²⁴⁵ Nonetheless, the Ombudsman wrote that the creation and general acceptance of the JPSU/IPSC structure appeared “to be providing improved management of ill and injured.”²⁴⁶ Despite some hiccups, the JPSU promised better and more standardized care for those in need than previously disparate measures.²⁴⁷

Master Warrant Officer Barry Westholm, whose story was recounted in the first chapter, thought the JPSU was a “stellar idea.”²⁴⁸ In 2009, he quit the Regular Force – a “huge decision”

²⁴² Barabé interview.

²⁴³ See earlier discussion of the Universality of Service principle during the Croatia Board of Inquiry.

²⁴⁴ Pierre Daigle, *Fortitude Under Fatigue*, 22.

²⁴⁵ *Ibid.*, 24.

²⁴⁶ *Ibid.*

²⁴⁷ *Ibid.*

²⁴⁸ Westholm interview.

– to sign on as a Reservist, a requirement to join the JPSU.²⁴⁹ After numerous interview stages and screening processes he was accepted, becoming the first regional Sergeant Major for the JPSU in the eastern Ontario region, the most senior position of a non-commissioned officer in the unit.²⁵⁰ Initially, he felt the staff level was adequate and that overall the unit ran smoothly. What he discovered shortly after work began though, was that the JPSU was already at an “end state.”²⁵¹ No provision was made for any staff increases as the number of personnel posted to the Unit grew. Thus, after the early “great success,” the Unit became inundated when existing personnel were forced to handle a sharp climb from approximately 100 to 500 soldiers posted to it.²⁵² In spite of their best efforts JPSU staff became, in Westholm’s words, “overwhelmed.”²⁵³ He recalled that “the people that suffered were both the staff and the people posted-in.”²⁵⁴

As the situation deteriorated Westholm felt an inner conflict about the need to obey his superiors *and* his responsibility to the ill and injured soldiers under the Unit’s care. The inability of staff to keep up with the heavy workload meant that, in his mind, they were putting ill and injured soldiers “in harm’s way.”²⁵⁵ In a testament to the situation’s severity, Westholm recalled: “We did lose people to suicide. And although I could never state categorically that the situation in the JPSU contributed to the suicide, I can say that we didn’t do enough to prevent them ... Because we couldn’t get to them all in time.”²⁵⁶ He attempted to carry on, but shortly after the January 2013 suicide of Master Corporal Charles Matiru, a four-time Afghanistan veteran who committed suicide after suffering from PTSD, Westholm resigned in protest — one of the

²⁴⁹ Ibid.

²⁵⁰ Ibid.

²⁵¹ Ibid.

²⁵² Ibid.

²⁵³ Ibid.

²⁵⁴ Ibid.

²⁵⁵ Ibid.

²⁵⁶ Ibid.

strongest gestures a military member could make.²⁵⁷ His very public decision was meant to draw attention to the JPSU's "dire need for assistance."²⁵⁸ Thus he laid everything on the line and "grenaded" all his bridges.²⁵⁹ He subsequently sent a document to the Governor General, Prime Minister, and numerous military leaders, outlining both the hard work of JPSU staff and their tragic inability to cope with the demands placed on them.²⁶⁰ Westholm's commanding officer informed him that his behaviour was "very much a disappointment" and he was later told to "just stay home," an order he nonetheless refused to follow.²⁶¹ Although his resignation did not make the splash he hoped for, a series of *Ottawa Citizen* articles in 2013, partially responsible for a late-2013 Ombudsman's investigation into the JPSU, lent credence to Westholm's claims.²⁶² A year after his resignation he told *Citizen* reporter Chris Cobb that there was a "spectre of indifference" towards veterans within the federal government.²⁶³

Ombudsman Pierre Daigle's 2013 preliminary assessment of the state of the JPSU bolstered Westholm's assertions and raised more red flags. Although JPSU commander Colonel Gerry Blais described staff levels as adequate, after soliciting comments from sixteen JPSU staff and 177 clients, Daigle wrote that "60% of interviews referenced insufficient staff numbers relative to JPSU member and client demands."²⁶⁴ His assessment concluded: "Observations made during this review suggest there may be a requirement to review overall governance of support offered to ill and injured members."²⁶⁵ Several months later, the *Ottawa Citizen* once

²⁵⁷ Ibid; *The Ottawa Citizen*, 17 October 2014.

²⁵⁸ Westholm interview.

²⁵⁹ Ibid.

²⁶⁰ Ibid.

²⁶¹ Ibid.

²⁶² *The Ottawa Citizen*, 29 June, 2015.

²⁶³ *The Ottawa Citizen*, 3 February 2014.

²⁶⁴ Pierre Daigle, Ombudsman National Defence and Canadian Armed Forces, *Preliminary Assessment – Joint Personnel Support Unit (JPSU)* (Ottawa: Department of National Defence, 2013); *The Ottawa Citizen*, 2 February 2014.

²⁶⁵ Daigle, "Preliminary Assessment."

again drew attention to systemic problems outlined by Daigle, with Chris Cobb writing that the JPSU still remained understaffed.²⁶⁶ Despite requests for figures on the situation at Petawawa and Ottawa, considered “the most overloaded and inefficient units,” JPSU staff refused to provide the *Citizen* the information Cobb wanted.²⁶⁷ For all of its hard work, the JPSU was, by 2014, “widely criticized by serving soldiers, veterans of JPSU and military mental health specialists.”²⁶⁸

The year 2014 began as another bad one for the Unit, as eight CAF suicides in a little over two months between the end of 2013 and early 2014 brought more criticism from veterans’ advocates.²⁶⁹ The case of Lieutenant-Colonel Stéphane Beauchemin was another controversial moment. A veteran of Haiti and Bosnia operations in the 1990s, Beauchemin was posted to the JPSU on a return-to-work program when he committed suicide in January 2014. His death once again implied serious problems within the CAF mental health network.²⁷⁰ Moreover, late in 2014 the situation became desperate as the Ottawa IPSC, one of the busiest in the country, lost two of its staff members, leaving two Section Commanders to assist more than 225 injured personnel.²⁷¹ While the Centre attempted to regroup, soldiers with urgent crises, including PTSD, were told to call 911 or visit Ottawa’s Montfort Hospital.²⁷² IPSC platoon commander Lieutenant (Navy) Adam Winchester said that the Centre’s tempo had “rapidly increased.”²⁷³

While JPSU staff continued to battle their workload and veterans’ groups expressed dissatisfaction, in 2015 the Department of National Defence “quietly shelved” an internal investigation into the Unit, stating that a report would not be completed until sometime in

²⁶⁶ *The Ottawa Citizen*, 2 February 2014.

²⁶⁷ *Ibid.*

²⁶⁸ *Ibid.*

²⁶⁹ *The Ottawa Citizen*, 19 January 2014.

²⁷⁰ *Ibid.*

²⁷¹ *The Ottawa Citizen*, 5 November 2014.

²⁷² *Ibid.*

²⁷³ *Ibid.*

2017.²⁷⁴ That decision was a disappointment to Ombudsman Gary Walbourne, who previously halted his 2013 probe based on an understanding that the DND would issue its own report by summer 2015.²⁷⁵ Regardless, Walbourne refused to wait, and in July 2015 began his own investigation, stating that given the JPSU's importance for ill and injured troops, a report was necessary "now, rather than later."²⁷⁶ Others agreed. Retired Corporal Chris Dupée, the founder of Military Minds, a 130,000 person online PTSD awareness group founded in 2011, told the *Ottawa Citizen* that the system continued to fail many of its injured, who were "falling through the cracks."²⁷⁷ In the same article, Westholm commented that the JPSU had great potential but was "horribly mismanaged at the highest level."²⁷⁸ Thus, although important initiatives and reforms had been made since the new millennium, fifteen years later there were still many individuals from within and outside the military who believed the system let many soldiers and veterans down, sometimes with devastating consequences. Military leaders and DND officials were cognizant of the need to admit the existence of mental health problems amongst a segment of the CAF and veteran population, but they were still unwilling to admit when they had a tiger by the tail. Instead, they fell back on a tried and tested method: deny the problem's extent until it blew over. Numerous soldiers and veterans suffered while the PR battle continued.

²⁷⁴ *The Ottawa Citizen*, 29 June 2015; Defence Minister Jason Kenney later ordered the DND to release data it had gathered during its investigation beginning in August 2013.

²⁷⁵ Ibid.

²⁷⁶ Ibid.

²⁷⁷ Ibid; For more on Military Minds, see <http://www.militarymindsinc.com> (accessed April 12, 2015).

²⁷⁸ Ibid.

CONCLUSION: ENDURING STRUGGLES AND ENDURING HOPE

As the Afghanistan War continued throughout the 2000s and early 2010s, the number of physically and mentally injured soldiers increased exponentially. Concurrently, while casualties grew the precise number of psychologically injured troops became a thorny issue. Similar to past conflicts, rates and figures widely varied. A 2007 *Toronto Star* article featuring an interview with Dr. Mark Zamorski stated that about 28% out of a total of 2,700 CAF soldiers screened after Afghanistan had symptoms of mental health problems.¹ An April 2009 *Toronto Star* article featuring figures provided by VAC spokesperson Janice Summerby stated that one in five deployed to Afghanistan – 1053 Canadian soldiers and police officers – later left the CAF and RCMP with PTSD or other psychiatric problems.² The article further reported that VAC expected an increase in the total numbers over time.³ In her 2008 report on OSIs Interim CAF/DND Ombudsman Mary McFadyen avoided using exact figures, but inferred that the number of soldiers and veterans with psychological difficulties was likely in the thousands.⁴ Yet another *Toronto Star* article from 2010 said the number of Afghanistan veterans with PTSD was about 5% – “at least 1250.”⁵ Figures like those were enough evidence for conservative and controversial *Globe and Mail* columnist Margaret Went to agree with Lewis MacKenzie. She believed numerous soldiers and veterans were abusing the system: “[W]hen stress is mowing down far more troops than the Taliban, maybe something’s out of whack.”⁶ But in spite of

¹ *The Toronto Star*, 29 October 2007.

² *The Toronto Star*, 14 April 2009.

³ Ibid.

⁴ Mary McFadyen, *A Long Road to Recovery*, 1.

⁵ *The Toronto Star*, 6 November 2010.

⁶ *The Globe and Mail*, 6 July 2006; Went also implied that Second World War or Korean veterans being awarded pensions for PTSD in the early 2000s – “long after the fact” – was further evidence that new CAF/DND initiatives and a national consciousness about PTSD “sometimes increases disability.” Such comments flew in the face of overwhelming evidence about PTSD symptoms in many veterans. At Sunnybrook Hospital in Toronto, nursing staff working with Second World War veterans made great efforts to avoid “triggering” flashbacks and traumatic

Wente's assessment, a consistent stream of reports suggested the number of casualties was growing.

While a perennial debate over the extent of psychological casualties continued, the public's attention was drawn to another dark shadow of the Afghanistan War – suicide. Throughout the 2000s, the Canadian public became aware of numerous instances of suicide amongst CAF members. In 2009, for example, there were sixteen recorded CAF personnel suicides, the highest annual number since tracking began in 1995.⁷ In late 2013, four soldiers committed suicide in just one week.⁸ One of them, Master Corporal Sylvain Lelievre from the Van Doos Regiment, had deployed to Bosnia three times before serving in Afghanistan in 2010.⁹ The quick succession of suicides in 2013 led former Chief of the Defence Staff and charismatic General Rick Hillier, “Uncle Rick” as he was affectionately called by troops, to call for a board of inquiry or Royal Commission.¹⁰ Although suicides were difficult to directly link to deployments, they nonetheless raised further questions about the CAF's approach to mental illness and the extent to which support mechanisms were failing troubled soldiers.¹¹ More pressure was placed on the CAF and federal government when DND statistics revealed that by 31 March 2014 more soldiers had been lost to suicide (160) than combat in Afghanistan (138) between 2002 and 2014.¹² Those statistics, which included Reservist suicides, a category left out

memories for vets still traumatized decades after the War ended. For three such articles on the care of older veterans see *The Toronto Star*, 11 November 2005; 7 November 2009; 12 November 2009.

⁷ Brock and Passey, 91.

⁸ *The Globe and Mail*, 4 December 2013.

⁹ Ibid.

¹⁰ *The Huffington Post*, “Rick Hillier Calls for Public Inquiry in Wake of Soldier Suicides.”

http://www.huffingtonpost.ca/2013/12/14/rick-hillier-soldier-suicides_n_4444402.html (accessed January 25, 2015).

¹¹ *The Globe and Mail*, 4 December 2013; It is difficult to derive conclusions from these numbers since the DND is, unsurprisingly, very tight-lipped about suicides, and many of the soldiers included in these figures had not deployed to Afghanistan.

¹² *The Toronto Star*, 16 September 2014; National Defence and the Canadian Armed Forces, “Suicide and Suicide Prevention in the Canadian Armed Forces.” <http://www.forces.gc.ca/en/news/article.page?doc=suicide-and-suicide-prevention-in-the-canadian-armed-forces/hgq87xvu> (accessed April 4, 2015).

in past tallies, led opposition MPs to accuse the federal government of “lowballing” earlier numbers to downplay the issue.¹³

One of the most troubling cases was that of Corporal Stuart Langridge, a “dedicated, loyal and motivated” veteran of the Former Yugoslavia and Afghanistan who committed suicide in his room at CFB Edmonton after struggles with depression, alcohol, and drugs — all potential signs of PTSD.¹⁴ In the aftermath and ensuing investigation, many disturbing details emerged about both Langridge’s case and the Canadian Forces National Investigation Service’s (CFNIS) handling of the matter. Langridge’s stepfather Shaun Fynes accused the CFNIS of withholding Langridge’s suicide note for fourteen months. He claimed the note revealed Langridge had PTSD and thus was withheld as part of a “very calculated deception to protect the uniform from embarrassment.”¹⁵ Mr. Fynes later told a Military Police Complaints Commission (MPCC) inquiry that Langridge was “ping-ponged” between civilian and military medical systems, with the former not wanting to deal with him and the latter not knowing what to do.¹⁶ Both Mr. Fynes and his wife Sheila, Langridge’s mother, claimed their son was treated as a drunk and addict by superior officers.¹⁷ Mr. Fynes declared before the Commission that Corporal Langridge was essentially “killed by the military.”¹⁸ Adding to the controversy, after the MPCC inquiry ended *Ottawa Citizen* reporter Chris Cobb revealed that the sixty-two day inquiry and investigation cost more than \$3.5 million.¹⁹

¹³ *The Toronto Star*, 16 September 2014.

¹⁴ Military Police Complaints Commission of Canada, “Backgrounder – Fynes Public Interest Hearing.” <http://www.mpcc-cppm.gc.ca/01/400/fynes/2015-03-10-1-eng.aspx> (accessed August 3, 2015); *The Ottawa Citizen*, 27 March 2015; Thanks and acknowledgements to Chris Cobb for discussing details of the case and his investigation by phone and through e-mail.

¹⁵ *The National Post*, 6 September 2012; See also *The Toronto Star*, 30 October 2010.

¹⁶ *The National Post*, 5 September 2013.

¹⁷ *The Ottawa Citizen*, 27 March 2015.

¹⁸ *Ibid.*

¹⁹ *Ibid.*; Details of the case and the final MPCC report can be viewed online.

The Langridge case and its aftermath received national media attention and exposed controversies that proved embarrassing for CAF and DND officials. In one particularly strange instance, Cobb's colleague David Pugliese at the *Ottawa Citizen* claimed that in 2010 he was asked, or rather urged, to discontinue writing about the Langridge case by an officer ostensibly working for the Chief of Defence Staff.²⁰ Pugliese suggested that CAF and DND leaders were upset because, "The Langridge story challenged the military's and government's message that Afghan veterans were being taken care of" and drew national media attention to the implied link between post-traumatic stress and suicide.²¹

Legacies and Dilemmas

By the end of Canada's Afghanistan combat operations in July 2011, over 40,000 service personnel had been deployed there, making the Afghanistan War the largest Canadian military operation since the Second World War.²² During the War, 158 soldiers died, and 1,859 members were physically wounded.²³ Moreover, of the 25,000 to 35,000 military members expected to release from the CAF between 2011 and 2016, at least 2,750 were predicted to suffer from a

²⁰ *The Ottawa Citizen*, 12 March 2015; Pugliese wrote that he was told if he did not stop writing about the Langridge case he would no longer be granted interviews with Chief of the Defence Staff Walter Natynczyk. The same article listed other controversial aspects of the case: "Documents clearly naming Sheila and Shaun Fynes as primary and secondary next of kin were ignored. Mistakes were also made on the soldier's death certificate. The Fyneses had to spend \$12,000 in legal fees to correct the inaccuracies."

²¹ *Ibid*; Arguably, Dallaire's vocal discussions of PTSD and suicide in print and in several documentaries drew a link between the two earlier, but the Langridge case certainly helped to propel it further into the spotlight; Another high-profile suicide case was that of Major Michelle Mendes, who committed suicide in Afghanistan on 23 April 2009. PTSD was not as strongly implied, but it was revealed that she was injured in a friendly-fire incident supposedly involving NATO planes in 2006 during her first Afghanistan tour. For three articles on the subject see *The Globe and Mail*, 20 June 2009; *The Toronto Star*, 24 April 2009; 25 April 2009; The suicide discussion continued to be a source of controversy, and in 2014 led to another public conflict between Stogran and Mackenzie. For more on the controversy see *The Globe and Mail*, 14 February 2014; *The Ottawa Citizen*, 17 February 2014.

²² Jean-Rodrigue Paré, Legal and Social Affairs Division, Parliamentary Information and Research Service. "Post-traumatic Stress Disorder and the Mental Health of Military Personnel and Veterans." Publication No. 2011-97E. Ottawa: Library of Parliament, 2011 [Revised 2013], 1; National Defence and the Canadian Armed Forces, "The Canadian Armed Forces Legacy in Afghanistan." <http://www.forces.gc.ca/en/operations-abroad-past/cafla.page> (accessed February 12, 2015); Figures vary, with the former source by Paré stating 30,000, while both the VAC and CAF/DND websites state 40,000. The latter figures have been used here.

²³ *Ibid*; Four civilians were also killed.

severe form of PTSD, and a further 5,900 were predicted to suffer from other diagnosed mental health problems.²⁴ In terms of concrete figures, as of March 2010 VAC psychiatrists had 12,689 total cases, with PTSD numbering 8,758 of those.²⁵ By April 2015, since its inception in 2001 the OSISS network had assisted 10,181 peers, indicating both the past and future need for its services.²⁶ The creation of groups such as Wounded Warriors Canada, a non-governmental organization assisting physically and mentally wounded soldiers through a series of national programs and events, was also a sign that government initiatives were not always enough.²⁷ Retired Brigadier-General Christian Barabé matter-of-factly stated that although Wounded Warriors and similar groups provided excellent and necessary assistance, their very existence demonstrated “that there are deficiencies in the system.”²⁸

At present, soldiers and veterans with psychological illness still also face the possibility of ostracism by their colleagues, friends, and superior officers. Even in the second decade of the twenty-first century, problems of the mind are often interpreted by military members as a sign of weakness.²⁹ Those stigmas, which exist in civilian society as well, are heightened in a military milieu. The John Wayne figure – tough, stoic, brave, and seemingly invincible – still forms the manly ideal for much of Canadian and North American society, especially amongst those in the military.³⁰ Despite decades of medical and socio-cultural changes, which saw the dominant image(s) of masculinity bend and mental illness no longer interpreted through overtly gendered

²⁴ Ibid., 2.

²⁵ Brock and Passey, 93; It is important to note that some of these cases were veterans of earlier conflicts stretching back to the Second World War. Nonetheless, it can be inferred that a high number of them were from Afghanistan and 1990s peacekeeping operations.

²⁶ Thanks to retired Chief Warrant Officer and OSISS National Coordinator James Woodley for these figures. James Woodley, e-mail message to author, August 6, 2015.

²⁷ Wounded Warriors Canada, <http://woundedwarriors.ca/home/> (accessed April 4, 2015).

²⁸ Barabé interview.

²⁹ Allan English, “From Combat Stress to Operational Stress,” 10.

³⁰ This problem is evidently a common one for militaries in the West. For a brief comparative overview see Hazel Croft, “Emotional Women and Frail Men: Gendered Diagnostics from Shellshock to PTSD, 1914-2010,” in Carden-Coyne, *Gender and Conflict since 1914*, 110-123.

medical theories, traditional masculinity still pervades civilian and military society.³¹ Even the rise of the double-income family and working mother, initially viewed by many as a sign of men's social decline, has not thoroughly damaged the belief that a man's identity is tied to his role as breadwinner and family leader.³² The military's fitness culture and a heightened need to adhere to masculine norms combine to convince many soldiers that the best approach to any physical or mental problems is to "tough it out."

In the Canadian Forces, socio-economic concerns, namely remaining with the military and worries of peer rejection, have led to a perennial stigma and fear surrounding mental illness. Retired Lieutenant (Navy) Bruce McKay, a Chaplain who served from 1980 until 2013, spoke with hundreds of soldiers about their innermost thoughts and private matters throughout his career. By the late 2000s he saw changes in how troops spoke about mental health problems, with fewer soldiers entirely denying when something was wrong. Nevertheless, he noticed that instead of openly acknowledging problems, many opted for euphemistic statements such as "I'm just dealing with some stuff at home."³³ McKay also noticed reluctance among numerous soldiers to see military medical staff or social workers, because such information went into their personnel file. The decades-old fear of their problem "getting out" persisted.³⁴ Troops' worry that private information expressed during appointments would somehow reach their superiors or colleagues was enough to keep many silent. In an attempt to seek some form of help, soldiers sometimes requested private discussions with McKay. During those conversations they would

³¹ Mosse, *The Image of Man*, passim, esp. 180-194.

³² Christopher Dummitt and Susan Holloway, "Canadian Manhood(s)," in Greig and Martino, *Canadian Men and Masculinities*, 127.

³³ McKay, Bruce. Interview by author. Telephone. Toronto, August 7, 2014.

³⁴ Ibid.

“talk about ‘can’t sleep,’ would talk about nightmares, [and] they would talk about how they’ve woken up strangling their wife and things like that.”³⁵

For many dealing with emotional difficulties or psychological stress, social support proved a key factor in their resiliency. Master Corporal Toby Prigione, due to be released from the military in 2014 because of mental and physical health matters, stated that family and groups like OSISS were particularly helpful. She stated that, quite simply, “It’s always nice just to have someone who’s willing to listen.”³⁶ Retired Sergeant Derek Spracklin, a veteran of Bosnia, Kosovo, and Afghanistan, likewise believes in the power of support: “You definitely need a good support network.”³⁷ Like Greg Prodaniuk, Spracklin aimed to use his positive experiences with social support and “gift of the gab” to help others: “I love sitting down with guys, chatting about coffees, chatting about stories, and trying to help them along ... When you sit down with the groups of guys and girls [in OSISS group sessions] ... it gets people understanding ... everybody has had their own problem ... Out of ten people, nine have gotten through it and you’re the one that’s waiting to get through it.”³⁸ Spracklin believes that with regard to mental health problems, sometimes there is “more to it” than medical diagnoses.³⁹

For retired Sergeant Daniel Hrechka, a veteran of two Middle Eastern peacekeeping tours, family and peer support were a critical factor in getting over traumatic events. Since being diagnosed with PTSD in 2010, “it’s been family and peer support ... hanging with other guys that are going through ... different stages of their healing process.”⁴⁰ Hrechka affirmed that “being with like-minded soldiers is a really warming feeling” because “we know we’re surrounded by

³⁵ Ibid.

³⁶ Prigione, Toby. Interview by author. Telephone. July 29, 2014.

³⁷ Spracklin, Derek. Interview by author. Telephone. August 19, 2014.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Hrechka, Daniel. Interview by author. Telephone. July 24, 2014.

people that get it.”⁴¹ He found it difficult to discuss his problems with civilians, particularly because of his injury’s invisible character: “You look at me, you don’t see anything wrong. That’s the constant battle with the civilian population. [They say] ‘There’s nothing wrong with you, Dan, you’re fine.’”⁴² Myths and misconceptions made support from those that “get it” all the more crucial for normalizing his experiences and path to recovery.⁴³

The military must train men and women to be tough, so that they are able to face all manners of physical and mental duress. That axiom was crudely but accurately summarized by one soldier during the Croatia Board of Inquiry: “You have to train them to be dangerous weapons ... You can only put so much of a leash on a pit bull because you know he has still got to be the pit bull if need be.”⁴⁴ How to train a “pit bull” and still have him or her show empathy towards injured comrades is the biggest dilemma the military faces in any attempt to reshape CAF culture. Injuries to the body or mind, especially the latter, which are often invisible and subject to numerous discretionary factors, challenge the warrior ethos that the military instills. The ideal warrior of earlier eras has changed in numerous ways, and there can be no doubt that soldiers with psychological injuries are, by and large, better off than their counterparts in the twentieth century. Nevertheless, as this dissertation has demonstrated, there are still numerous obstacles ahead. One of the military’s biggest challenges will be to convince soldiers to abandon the “cult of the strong, silent individual” who bears all suffering stoically in favour of a team-oriented approach to health and wellness.⁴⁵ When queried about change over time, Brigadier-General Sharpe stated that in the past fifteen years he saw “a growing acceptance of the team at

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

⁴⁴ Testimony of MWO Patrick Lawler, *Croatia Board of Inquiry*, October 18, 1999, vol. XIX, 12.

⁴⁵ G.E. Sharpe, e-mail message to author, June 1, 2015.

the core of the warrior ethos.”⁴⁶ The challenge, he wrote, was “to get that culture to continue to evolve.”⁴⁷

By examining trauma in the Canadian military during the post-1991 period, something hitherto only addressed in article-length studies, this dissertation has brought together events and themes previously discussed in a disparate manner, and created future opportunities for comparative histories that draw on the experiences of veterans from different eras. This study has begun to fill a gap in the Canadian historical literature on war trauma, much of which has revolved around the historical experience of shell shock during and after the First World War. Recounting the Canadian military experience with trauma after the Cold War, it has highlighted the persistence of trauma narratives all throughout the nation’s participation in war and peacekeeping operations after 1914, and demonstrated the numerous ways that history can provide sign posts for contemporary and future discussions. At the same time, it has considered the ways that individual experiences are shaped by, interact with, and alter prevailing cultural ideas of trauma. Listening to post- Cold War veterans’ experiences helps us to understand that while trauma has been a persistent theme in modern wars and peacekeeping, its expression and conceptualization has been framed by historical contingencies. This speaks to the need to continue exploring those contingencies, as well as the various lenses that trauma is viewed through by physicians, the military, politicians, the public, and of course, soldiers themselves.

From an historical perspective, Sharpe’s aforementioned thoughts on military culture and the many reform initiatives to de-stigmatize mental illness support historian Mark Micale’s belief that the early twenty-first century represents a unique cultural and historical moment for discussing topics, such as masculinity and mental illness, which were previously kept hidden

⁴⁶ Ibid.

⁴⁷ Ibid.

from view.⁴⁸ Like Paul Jackson's 2004 work on homosexuality in the military during the Second World War, this dissertation is a product of a more open approach to topics previously, and entirely, taboo for the military, general public, and historians.⁴⁹ One inadvertent effect of Canada's peacekeeping and war operations of the 1990s and 2000s was that they contributed to a reappraisal of decades-old approaches to mental injuries. Traditional approaches, which left numerous troubled veterans to seek reminiscences with comrades over a beer at their local Legion, no longer sufficed. In battling psychological injuries, the military, physicians, and the Canadian public were forced to look inward and acknowledge the individual, institutional, and cultural beliefs that kept such topics off the table for so long. Importantly, this introspection also involved addressing predominant views of the ideal man and warrior.

Peacekeeping trauma, and later the Afghanistan War, brought mental health problems out of the shadows, and CAF reformers contributed to a national dialogue on a previously unseen scale. The lived experiences of those who publicly shared their stories during the Croatia Board of Inquiry, and after Afghanistan, highlighted the political, medical, societal, and cultural factors that shaped trauma discussions throughout the late twentieth and early twenty-first century. Trauma, moreover, forced a reappraisal of Canada's role in international affairs. The question, still under debate in 2015, is, if peacekeeping is no longer peaceful, and wars are seemingly no longer winnable in a traditional sense, what role should Canada play on the world stage? The Afghanistan conflict temporarily brought war back as the military's *raison d'être*, but with the mission's end in 2014 it remains to be seen how Canadians will reconcile their dual image as both peacekeepers and warriors, and if peacekeeping will once again become the military's primary role during international conflicts.

⁴⁸ Micale, *Hysterical Men*, 284.

⁴⁹ See Jackson, *One of the Boys*, 3, where he states that earlier in history his book could not have been written.

This dissertation is in many respects a product of the dialogue and events it has related. The experiences shared by CAF members and veterans, some of whom have been quoted in this study, represent a unique historical moment when Canadian veterans, for the first time, have been willing to publicly express the consequences of PTSD, or whichever term we choose for psychological injuries resulting from traumatic experiences. The historical legacy of shell shock, battle exhaustion, PTSD, and newer terms like OSI, support the opinion shared by numerous historians that psychological trauma and psychiatric language are shaped by cultural beliefs produced and altered within a war – and in the Canadian case – peacekeeping context. The creation of the OSI term, a military solution to CAF cultural beliefs about “disorders,” demonstrates the contingency of language utilized to encapsulate trauma’s effects, and psychological illness more broadly.

It is unclear what psychiatrists will choose to call PTSD in the future, and how that term will be altered, but historical evidence suggests we are far from at an end point when it comes to medical terminology connoting trauma.⁵⁰ Despite its status as a non-medical term, the creation of new concepts like OSI suggests a continuing tension between a universal representation of trauma encapsulated in the PTSD concept and the lived experiences of those exposed to it, as well as the power of institutions like the military to shape cultural beliefs. Psychiatric terminology, despite numerous attempts, is still unable to capture and keep hold of the myriad ways that trauma is *socially* refracted by individuals and societies. History suggests it will be a long time, if ever, before psychiatry will be able to accomplish such a formidable task. Equally important, just like shell shock, battle exhaustion, and PTSD stemmed from wartime and peacekeeping encounters with trauma, the creation of the OSI term demonstrated the continuing

⁵⁰ This is demonstrated above all else by the continuing evolution of the *Diagnostic and Statistical Manual of Mental Disorders* and the numerous – too many to list here – criticisms of its growth.

ability of military needs to influence cultural representations of trauma. The tension between medical authority, sympathy toward psychological injury, and the CAF's desire to preserve manpower, will likely continue for a long while yet.

Canadians have justifiable reasons to take pride in our nation's military heritage, much of which has been forged by war deeds and numerous peacekeeping operations around the globe. As the title of Jack Granatstein's book suggests, a great deal of our nation's historical experience has been shaped by "Waging War and Keeping the Peace."⁵¹ Our historical record towards injured veterans, and particularly those psychologically debilitated by military service, has unfortunately been less admirable. Throughout the past one-hundred years, many veterans' road to hell was paved by the ostensibly good intentions of politicians and pension officials. That road was also paved by persistent mental health stigmas and unrealistic expectations of what it meant to be a proper man and soldier. A lamentable ambivalence and national blind spot has sometimes characterized the Canadian public's attitude toward injured veterans, and with each passing conflict Canadians seem to gradually forget about those who bore the brunt of our foreign policy decisions. This ambivalence has been most evident with regard to the "new" generation of post-Cold-War-era veterans, those who have participated in peacekeeping missions and conflicts that did not have the easily defined good-versus-evil narratives of the First and Second World War. Many Canadians know little to nothing about their deeds. Relatively speaking, their numbers are much smaller than their early- to mid-twentieth century counterparts. But as thinkers across time have stated, the true test of a nation's morals and values is how it treats its more vulnerable citizens.

In our collective desire to form a national identity based on our most treasured values, we must not forget about those who have witnessed the worst in humanity and committed sanctioned

⁵¹ J.L. Granatstein, *Canada's Army*.

acts of violence on our behalf, for they have in many cases sacrificed their mental health for the nation. In the conflict between how wars and peacekeeping missions are memorialized, and their often grim reality, veterans of all ages represent our closest link to the past.

Final Thoughts

Since this story opened with an anecdote about Canadian veteran Barry Westholm, it seems fitting to conclude with a brief tracing of the subsequent path taken by the reformers and psychologically injured veterans discussed throughout its narrative.

After he left the Joint Personnel Support Unit in 2013, Westholm became an advocate for physically and mentally injured soldiers. He frequently counsels and supports injured soldiers, particularly with the complex and labyrinthine process involved in seeking compensation for injuries. He also acts as the proverbial bee in the bonnet of CAF and DND officials, frequently sending e-mails to politicians and military leaders about an injured soldier's situation, suggesting remedial action be taken or hastened. Given his long career, personal battle with PTSD, and experiences with the JPSU, Westholm is a fount of knowledge about the treatment of injured soldiers, and his thoughts and efforts have been spotlighted numerous times by the *Ottawa Citizen*. He divides his time between advocacy efforts and attempting to convince military and DND leaders to overhaul their system for aiding injured troops transitioning to civilian life, particularly the JPSU.

After his retirement in 2012, Stéphane Grenier began utilizing lessons learned from the OSISS experience in the civilian workplace. He currently works for Mental Health Innovations, an organization dedicated to bringing peer support initiatives and other innovations to the corporate environment. He sees many similarities between military and civilian mental health

issues, and believes Canadians as a whole need to address the stigmas that pervade our society: “Both [groups] will have a tendency to isolate, both will resist treatment, both will resist taking medication, regardless of the culture. Both will try to get over this [injury] themselves. Both will be embarrassed at the same level. Both will self-stigmatize.”⁵² Grenier still firmly believes in the power of social support, stating that, “Social support will provide hope, and with hope you can open the door to recovery.”⁵³

Joe Sharpe continues to work in several capacities, including as a patron for Veterans Emergency Transition Services, a non-profit corporation headquartered in Nova Scotia that provides aid to transient and homeless veterans across Canada. Recently, he has been “reactivated” as a strategic advisor to the CAF Strategic Response Team investigating sexual misconduct within the Forces – another perennial issue for the military.⁵⁴ Given his long and multifarious career with the military, he views the necessary reform of CAF culture not just as a prerequisite for better treatment for individual men and women of the Forces, but also “as a matter of operational readiness.”⁵⁵ He sees the continuing erosion of the “old culture” as one of the main challenges facing the military over the coming decades.⁵⁶ After the Croatia Board of Inquiry, Sharpe and Mike Spellen remained friends, and are still in regular contact with one another. When Spellen was asked his opinion about what needs to be done to combat systemic CAF problems he matter-of-factly replied: “The government’s got to stand up. Either that, or next time you want to go to war, send all the politicians over.”⁵⁷

⁵²Grenier interview.

⁵³Ibid.

⁵⁴Sharpe, e-mail message to author, June 1, 2015.

⁵⁵Ibid.

⁵⁶Ibid.

⁵⁷Spellen interview.

For Andrew Godin, life since retirement in 2006 has been “an ongoing battle.”⁵⁸ After his 1990s peacekeeping deployments he found himself increasingly disconnected from family, and physicians advised him not to seek employment. Godin found such advice difficult to heed because “every fibre in your body tells you [that] you should be out doing something ... the things that a man or a person is supposed to do.”⁵⁹ He thus tries to live “day to day,” and is involved with Wounded Warriors Canada, OSISS, and other veterans’ organizations. Like numerous colleagues, he believes social support from fellow veterans and Canadian society helps him navigate post-retirement life: “I have that [support] through my military family ... My family family, a little different story. They somewhat understand, but they don’t quite get it; which is fine, they weren’t supposed to get it. It’s not their job to get it. The military family, I’m still close to them. They understand. They know. They were standing there.”⁶⁰

As mentioned in the final chapter, Greg Prodaniuk became part of the first cohort of OSISS Peer Support Coordinators in 2001, and remains in that position to this day. In his work as a PSC, Prodaniuk aims to impart the benefits of social support on those he works with. He affirms that a lopsided focus on the medical dimensions of PTSD has failed to capture how military operations affect a soldier’s beliefs, morals, and outlook. His appraisal of the mental processes veterans work through after war and peacekeeping service demonstrates that like shell shock before it, PTSD is in many respects a metaphor for the profound impact trauma has on a soldier’s worldview:

I think people are [now] looking at these injuries sort of in a society sense, and just wheeling out the psychiatrists to explain what’s going on is kind of ringing hollow. It’s not filling in the parts of the story that people really want to engage ... I think the next change is we’re going to be evolving towards understanding this as a process, as a ... in

⁵⁸ Godin interview.

⁵⁹ Ibid.

⁶⁰ Ibid.

some ways almost looking at it as a grief model ... something everyone can relate to. Everyone loses people in their lives and it changes their lives, and how do they carry on? And I think that's really what happens here. Veterans lose something. They lose their youth, they lose their innocence, they lose some of their morals, [and] some of their ethics are challenged. They lose time, momentum, [and] access to the good life that happens in our country. And I think that that's really what we're talking about.⁶¹

Prodaniuk's story, like several others throughout this narrative, is a testament to how social support for those dealing with psychological difficulties can have very positive effects, above and beyond what medical treatment alone can offer. As this study has shown, social support is not just an individual, familial, or military concern, but a national one. Lastly, Prodaniuk's final interview remarks about his road to recovery demonstrate that viewing trauma as both an injury and a metaphor allows us to trace the difficult historical journeys of both individual Canadians and our nation:

I was prompted, encouraged, and decided to take the high road, and because of that I've opened up sort of a richness and understanding in my life, and a quality of life that I may not have achieved if I had gone down some other paths. So, when I reflect upon the injury, I see it as a definite point of deviation or a course change in my life ... I look at it as, ["I was a"] young guy who went on operations and I was impacted. And it moved me a few degrees at a critical point in a different direction, and I'm grateful that ... I had the wherewithal and the support to gain a perspective on it, and use it in turn to inform my life moving forward. I think it's made me a much better man. It's made me a much better father, better husband. It's made me a better leader. It's made me a more balanced person. It's taught me a lot, about the inner workings of people, and about how people approach impasses in their lives. And it's not so much an understanding as an overarching theory. It's more about the story of life and the things that you do in your youth, and the consequences of it, and where you go. And I think that's how I look at the injury now when I reflect back on it. I look at it as a significant moment in my life, and it's something that has created who I am, who I am now.⁶²

Prodaniuk's journey, and the other recounted stories, point to a new type of masculinity and leadership, and to the redrawing of what constitutes courage. Although Dallaire's high-

⁶¹ Prodaniuk interview.

⁶² Ibid.

profile battle with psychological difficulties is best known to Canadians, this new form of optimistic and courageous leadership goes beyond any one individual. Every soldier and veteran that comes forward about their own trials and tribulations, or approaches their colleagues' problems with an open mind, encourages a greater acceptance that manliness, and what constitutes the ideal soldier, need not be delineated with such sharp edges. There is room for a view that one can be both tough and compassionate, and that requiring help does not make one less of a man, woman, or soldier. While PTSD and other difficulties have brought some soldiers to ruinous decline, new ideas and approaches have provided many with opportunities not just for medical recovery, but for moral and spiritual recovery as well. This is a new chapter in a story of trauma and recovery that began long ago, and it is one that must continue to be written. If history is any indication of future directions, Canadians will continue to see the psychological fallout of the Afghanistan War for years to come, making the subject a perennial issue that must not fall off the public radar as memory of the conflict begins to fade.

This dissertation has used oral interviews with veterans to demonstrate the socio-economic and moral/spiritual effects trauma has had on Canadian military members across a one-hundred-year period. Without claiming that PTSD is simply a successor to shell shock or battle exhaustion, it has nonetheless shown that while terms and symptom patterns have changed, trauma has always had devastating social and moral effects on veterans; something that gets lost when too much emphasis is placed on medical narratives. Moreover, by thoroughly examining the history of trauma in the Canadian military after the Cold War, this dissertation has waded into largely uncharted territory to show that ideas and representations of trauma have consistently been wrapped up in individual, political, and societal concerns. This narrative has expanded on earlier historical accounts mentioned throughout, which focused largely on the

experience of trauma *during* war, rather than after it. Most importantly, this study has built on work by historians like Mark Humphries who recognize the value of a multifaceted approach that takes into account medical *as well as* cultural narratives. Future Canadian scholarship on veterans' trauma will no doubt continue to benefit from the combined use of social and medical histories, and the multidimensional perspective such an approach provides.

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